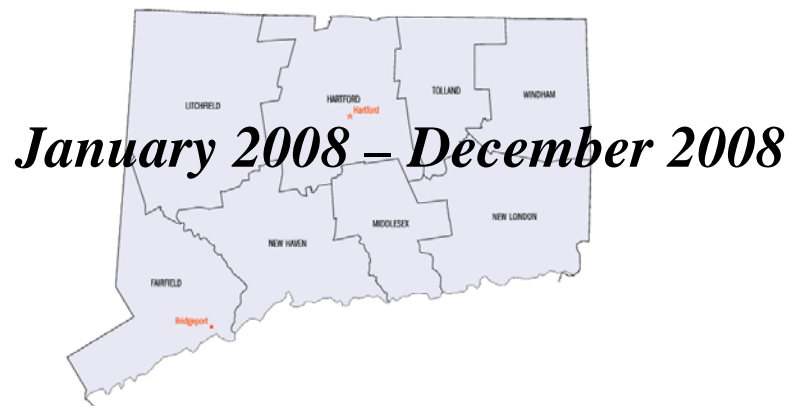


# **The Connecticut Comprehensive Statewide HIV/AIDS Care and Prevention Plan UPDATES**



**Ryan White CARE ACT Funded Programs  
&  
Community Planning Group**

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## Acknowledgements

This Comprehensive Statewide Care and Prevention Plan update for 2007-2008 is a product of collaborative planning meetings and writing efforts by various representatives of Ryan White Parts, the State of Connecticut Department of Public Health (DPH) provider agencies, consumers and public participants from across the state who share a high level of dedication to ensuring that a comprehensive continuum of care and prevention exists for residents of Connecticut.

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**A special thank you to individuals who provided data and additional effort in the planning process:**

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# CT COMPREHENSIVE STATEWIDE CARE AND PREVENTION PLAN FOR HIV/AIDS

## EXECUTIVE SUMMARY

### OVERVIEW

**The Connecticut Department of Public Health (DPH)** has a **sixteen year** history of responding to the HIV/AIDS epidemic and building a responsive policy and service environment to support PLWH/A. In 2004 Connecticut issued a three year plan (2004-2007) designed to integrate care and prevention and continue and improve upon the public health services system. The plan involved a comprehensive planning process to ensure that resources are efficiently and effectively used to deliver necessary core medical and support services in an ideal care system.<sup>1</sup>

The DPH convenes a Statewide HIV Care Consortium (SWC) with a primary mission to conduct statewide planning and to facilitate information sharing across local, regional and statewide programs involved in HIV/AIDS service delivery. The DPH charged the Consortium to develop this multi-year statewide Comprehensive Plan for the delivery of HIV/AIDS care services that informs the policy and Part B funding decisions implemented by DPH. The defining feature of the 2004 to 2007 Comprehensive Plan is the development of a plan that aligns HRSA and CDC expectations to integrate care and prevention while establishing an improved infrastructure for identifying priorities for the allocation of funds. The goal was to have by the year 2007, the highest level of integrated planning, funding and policy-making that supports a robust continuum of prevention and care services responsive to the needs of persons living with HIV/AIDS. At the time of this writing, the process is nearly complete. Each objective within the plan has been accomplished, the integrated care and prevention plan will be written and submitted in 2009, and the two distinct planning bodies will be fully integrated structurally and in all functions, including the planning, implementation and decision-making on matters relevant to HIV/AIDS care and prevention.

This update is a one year interim plan that outlines the accomplishments of the past three years, the process used by the Integration of Care and Prevention Committee (ICP) to combine the two statewide planning bodies, and the approach for the new planning body to develop its fully integrated care and prevention plan. This update provides the current picture of how the Consortium **analyzes data to identify the priority gaps in the statewide continuum of care, developed a process in collaboration with the Community Planning Group to create and implement a new plan, and ultimately design the best strategies** that will best address the gaps, realize an improved infrastructure for fund allocation, and result in a fully unified care and prevention plan for 2009.

### IDENTIFYING GAPS AND ASSESSING NEED: WHERE ARE WE NOW?

Connecticut (CT), New England's second smallest state, has a diverse population of approximately 3,500,000, a 4.3% unemployment rate, a 2005 median household income of \$57,369, and a statewide poverty rate of 7.6%. The five largest cities, Bridgeport, New Haven, Hartford, Stamford and Waterbury, report varying rates of poverty from 32% in Hartford to 8.7% in Stamford. In 2005, 9.4% of CT residents reported incomes under the Federal Poverty level (FPL). The 2006 CT Office of Health Care Access (OCHA) Household survey reported approximately 6.4% of the population (222,600) as uninsured, of which 36% are Hispanic. Statewide population distribution is 81% white, 9% black and 10% Hispanic. The majority of Hispanics are Puerto Rican, followed by Mexican, Cuban and others. Fairfield County has the highest per capita income (\$38,850) and Windham County has the lowest (\$20,443). CT consists of eight counties, of which Hartford, New Haven and Fairfield contain 75% of the population. The three largest cities, Bridgeport, New Haven and Hartford, also contain the highest percentage of Black and Hispanic populations, and approximately half of People Living with AIDS (PLWA) live in these cities. Higher incidences of poverty, unemployment, crime,

<sup>1</sup> Under the Ryan White CARE Act, the Comprehensive HIV Service Plan provides a common understanding of our current HIV/AIDS epidemic, a90

nd a framework to move Connecticut's system of care toward an ideal continuum of care.

drug use, homelessness, violence, inadequate or insufficient housing, and co-morbidities impact heavily on People Living with HIV/AIDS (PLWHA) in larger cities. Inadequate transportation and fewer support services define rural towns and communities. Nearly half (43%) of CT's cases are associated with injection drug use (IDU), with 19.5% associated with men who have sex with men (MSM), and 22.2% with heterosexual risk.

**AIDS:** The number of AIDS cases reported from 1980 to December 31, 2006 was 14,917. Of these, 7,607 (51%) have died and 7,310 are living with AIDS<sup>2</sup>. For persons living with AIDS, the majority of cases within all age groups are male, the percentage of cases that are Hispanic decreases with increased age and the percentage of White cases increases with age. The percentage Black remains approximately constant in all the age groups. IDU represents the highest risk across all age groups except for the 20-29 age group for which MSM is the highest risk. For cumulative cases, the majority of White males are MSM (52.9%) and with IDU at (28.5%), whereas among Black and Hispanic males the proportions are approximately reversed with 15% MSM and 60-62% IDU. White and Black females are more likely to be IDU while Hispanic females are more likely to be associated with heterosexual transmission. Of the 3,338 AIDS cases reported with MSM risk, 68.8% were White, 17.8% were Black, 12.8% were Hispanic. Among non-MSM males with risk known to be either IDU or heterosexual exposure 72-74% are IDU and 26-28% are heterosexual depending on race. Among females with known risk 44-56% were IDU and 33-47% are heterosexual depending on race.<sup>3</sup>

**HIV:** HIV infection has only been reportable in adults ( $\geq 13$  years of age) since January 2002. During 2002-2006, 3,247 HIV cases were reported to the DPH. Of these 686 (21.1%) were subsequently reported with AIDS and 61 died prior to being reported as an AIDS case. Of the 2,561 people living with HIV, 34% are white, 27.2% black, and 36.5% Hispanic. In 2006, 926 HIV cases were reported. HIV cases reported in 2006, in comparison with 2006 AIDS cases, were more likely to be female (HIV 39% vs. AIDS 36%), White (37% vs. 28%), younger (median age of 36 for HIV vs. 41 for AIDS), and were more likely to be initially reported without risk information (31% vs. 29%). An additional year or two of HIV reporting will be needed to substantiate these findings and establish trends. High numbers of chlamydia and gonorrhea cases in older teens and younger adults have also been reported in recent years suggesting the persistence of unprotected sexual activity. Similarly, the connection between MSM and both syphilis and hepatitis A nationally and in Connecticut, suggests resurgence in high-risk behavior in MSM that could lead to increases in HIV infection. In Connecticut, IDU is the predominant risk group for both hepatitis C and HIV.

**Needs:** The needs of PLWH/A corresponding with service priorities throughout the state are identified by the Data Work Group of the Statewide Consortium (SWC), Part A partners in Hartford and New Haven/Fairfield (NH/FF) counties, and the HIV Prevention Community Planning Group (CPG). Service priorities are specified in the updated 2007 Statewide Coordinated Statement of Need (SCSN) and incorporate various needs assessments used to establish the care priorities and prioritize populations and prevention interventions. This information assisted in addressing regional HIV /AIDS service planning for FY2007-2008. The CPG and Parts A and B collaborated on a 2005 statewide needs assessment survey instrument and implementation in 2005, and updated this information collaboratively through the Data Work Group in the revised 2007 SCSN. In addition, Parts A and B and the CPG also collaborated on a process to determine unmet need and a statewide out of care survey.

**Gaps:** The identified critical care and prevention service needs and gaps for PLWH/A as confirmed by the SCSN are: For core services, mental health and dental care. For supportive services, emergency financial assistance, food, outreach, housing related services and prevention support groups and services. Barriers to accessing care included inability to pay, fear, lack of transportation and being unaware of services and benefits. For those individuals identified as out-of-care, the problems continue to be the same in 2006 as they were in 2004 and 2002: barriers of transportation, fear, distrust, lack of insurance and substance abuse. Services that would facilitate individuals getting in to care include transportation, case management, and substance abuse treatment.

<sup>2</sup> Connecticut Department of Public Health. "Epidemiological Profile of HIV/AIDS in Connecticut" 2007

<sup>3</sup> CT DPH Website Statistics through June 2007

Ample room still exists for improving marketing efforts about service availability. HIV prevention and care services must prepare to address the emerging needs associated with specific target populations as indicated above as well as the age group of 50+ years, Hispanic, undocumented / migrant workers and continue to improve cross training among HIV/AIDS medical case managers and outreach workers and strengthen primary and secondary prevention efforts.

**Community Resources:** Connecticut has a broad network of prevention and care services that are available to state residents. In October 2006, an HIV/AIDS Prevention & Care Guide was launched on the United Way of Connecticut's 2-1-1 website. The Guide, a product of collaboration among 2-1-1, the CT DPH, the SWC, and the CT CPG was created to provide comprehensive information about HIV/AIDS services in CT. The Guide, which is accessible both online ([www.infoline.org](http://www.infoline.org)) and by dialing 2-1-1, provides up-to-date HIV/AIDS care and prevention information, as well as information about other resources beyond the scope of HIV/AIDS. In FY 2006-2007, the Part B provided services to 2,125 unduplicated clients through the Connecticut AIDS Drug Assistance Program (CADAP). More than 2,000 additional clients received services through Part B contractors and the Minority AIDS Initiative (MAI). Through CT state funded HIV Medication Adherence Programs, approximately 2,500 people received services. The DPH allocates funds to service providers based on the size and demographics of the HIV population, their needs and the availability of funds.

## **DEVELOPING A PROCESS TO INTEGRATE CARE AND PREVENTION: WHERE DO WE NEED TO GO AND HOW DO WE GET THERE?**

Pursuant to Section 2617(b)4) of the Ryan White Care Act, Connecticut developed a comprehensive plan for the organization and delivery of HIV health care and support services to be funded under Part B. The SWC created an Ad Hoc committee to oversee the development of the plan. The 2007 – 2008 Comprehensive Plan update is a product of collaborative planning meetings and writing efforts by various representatives of Ryan White Parts, provider agencies, consumers and public participants from across the state.

**The Connecticut Department of Public Health (DPH)** is in its 3<sup>rd</sup> year of a comprehensive planning process (2004-2007) to ensure that resources are efficiently used to deliver necessary medical and support services in an ideal care system.<sup>4</sup>

The SWC convened by the DPH, has continued its primary mission to conduct statewide planning and to facilitate information sharing across local, regional and statewide programs involved in HIV/AIDS service delivery. The multi-year 2004 to 2007 statewide Comprehensive Plan informs the policy and Part B funding decisions implemented by DPH and has a defining feature that aligns with HRSA and CDC expectations to integrate care and prevention while establishing an improved infrastructure for ascertaining priorities for the allocation of funds. By the end of 2007, Connecticut will offer the highest level of integrated planning, and by the end of 2008 the highest level of funding and policy-making that supports a robust continuum of prevention and care services responsive to the needs of persons living with HIV/AIDS.

The Connecticut Comprehensive Statewide Care and Prevention Plan for HIV/AIDS is in its final year of a multi-year 2004 – 2007 comprehensive planning process for the CT DPH to ensure that resources are efficiently used to deliver necessary medical and support services in an ideal care system.<sup>5</sup> Connecticut is making significant progress toward integrating care and prevention efforts that will result in a fully unified 2009 Care and Prevention Plan for HIV/AIDS services in Connecticut.

This document is an update to the 2004 – 2007 Plan spanning the period from December 31, 2007 to December 31, 2008. During that time period, the Statewide HIV Care Consortium will continue to implement the final stages as outlined in the 2004 – 2007 Plan and to write a fully unified care and prevention

<sup>4</sup> Under the Ryan White CARE Act, the Comprehensive HIV Service Plan provides a common understanding of our current HIV/AIDS epidemic, and a framework to move Connecticut's system of care toward an ideal continuum of care.

<sup>5</sup> Under the Ryan White CARE Act, the Comprehensive HIV Service Plan provides a common understanding of our current HIV/AIDS epidemic, and a framework to move Connecticut's system of care toward an ideal continuum of care.

plan for completion by the end of 2008. Factors influencing this decision to provide a one year transition plan for 2007-2008 include:

- The Comprehensive Plan established a timeline of 5 years to have a fully integrated plan. In the process of integrating care and prevention activities and increased collaboration, the planning bodies determined that a combined statewide planning body would be the most efficient and cost effective way to conduct public health planning for HIV/AIDS in the state of Connecticut. This combining of the planning bodies has thus far been a successful effort and will be fully combined by October 2007. December 2007 will be the first meeting of the combined planning body, the Connecticut HIV Planning Consortium (CHPC). This integration effort was highlighted at the HIV Prevention Leadership Summit (HPLS) in New Orleans, LA in May, 2007.
- The Reauthorization of the Ryan White Care Act resulted in the Modernization Act of 2006 released in December. The Modernization Act has made significant changes by setting minimum funding requirements for core medical services (75% for Parts A-C), creating new structures for funding, and changing the formula for distributing funds through Parts A and B.
- By the end of year 2008, Connecticut will offer the highest level of integrated planning, funding and policy-making that supports a continuum of prevention and care services responsive to the needs of persons living with HIV/AIDS through a combined Care and Prevention Plan.

System gaps addressed by the integration of care and prevention through the combining the two planning bodies and submission of a combined plan will continue to be address three focus areas:

- *Collaborative Planning* involves assessing unmet need and service gaps; aligning statewide planning processes to respond to service delivery issues; keeping the system flexible to respond to changing and/or emerging needs; keeping clients in care, and bringing those out of care or those who have never been engaged into the care system, developing a systematic approach to maximize funding resources; reviewing funding options and assessing duplication of effort; and coordinating planning across all HIV care and prevention related funded systems to maximize funding and resources.
- *Integration of Services* means instituting a new statewide data collection / tracking system – Uniform Reporting System; integrating separate components of the care system including Parts A and B services (Parts C and D for Medical Case Management) and Prevention; restructuring systems and identifying new resources to meet burgeoning demands and changing needs and addressing the impact of funding cuts with the change in designation of Connecticut's Eligible Metropolitan Areas to Transitional Grant Areas; working together between care providers through medical case management; ensuring that Connecticut's system is client centered; creating a cadre of support systems/options for individuals with medication adherence issues; incorporating into RFPs the process of linking care and prevention; working with all systems to create a unified system of care; and collaborating with other Ryan White Parts and funding sources to create a state standard for Quality Assurance and Medical Case Management.
- *Service Delivery* implies assisting entry and re-entry into care through collaborative outreach and a focus on hard to reach populations; improving secondary prevention efforts to maintain an individual's HIV status; providing HIV core medical and support services; increasing the number of HIV Support groups (supportive group sessions for those affected by or infected with HIV in order to reinforce prevention behaviors); exploring co-location of services; providing equitable access to care regardless of geography (e.g., rural or lower incidence areas), race, gender, age, sexual orientation or risk factor and ensuring that these services are user-friendly, readily and easily accessible, and culturally and linguistically appropriate; developing less burdensome documentation for providers, clients and case managers, maintaining access to HAART and a no-wait list for CADAP, moving clients into care at first HIV+ diagnosis, fully assessing clients needs when entering care, and increasing education and information (e.g., culturally, gender and age appropriate trainings; safe sex workshops).

Note: The CT HIV Planning Consortium and the CT Department of Public Health acknowledge that this is a “working document” spanning a period of one year only (1/01/08-12/31/08), and that it may undergo some changes once the new membership of the CT HIV Planning Consortium (CHPC) convenes and they begin their work. Also, note that for consistency, the former Ryan White Care Act Titles I, II, III and IV are referred to as the new Ryan White Parts A, B, C, and D per the Modernization Act of 2006.

## **DECEMBER 31, 2007 – DECEMBER 31, 2008: TRANSITION YEAR TO COMPLETE THE INTEGRATION OF CARE AND PREVENTION**

This document represents the culmination of the 2004-2007 plan to establish a process to integrate care and prevention, and a transition year during which the combined planning group, the Connecticut HIV Planning Consortium will create its first fully integrated HIV CARE and PREVENTION Plan for the State of Connecticut. The following pages provide an update to the 2004-2007 plan and outline a one year transition plan beginning with the overarching goals of the new CT HIV Planning Consortium (CHPC), its mission and the charge to complete the alignment of the two distinct care and prevention planning bodies into one united planning consortium.

### **2007-2008 OVERARCHING GOALS AND CHARGE TO ACHIEVE THE IDEAL CONTINUUM OF CARE<sup>6</sup>**

- To effectively combine the statewide care and prevention planning bodies into one CT HIV Planning Consortium
- To plan and write a fully integrated care and prevention plan
- To provide education sessions across the state to consumer groups and providers

### **The CT HIV PLANNING CONSORTIUM (CHPC):<sup>7</sup>**

**CT HIV Planning Consortium:** The Statewide body composed of 39 members existing to work collaboratively with and advise the State Department of Public Health and each Transitional Grant Area (TGA) on the provision of effective planning and the promotion, development, coordination, and administration of HIV/AIDS health care, prevention and support services.

**Mission:** To create a coordinated statewide care and prevention system in which the rate of new HIV infections is reduced, and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services.

**Charge:** Under the Ryan White Modernization Act, Connecticut is required to develop a comprehensive plan for the organization and delivery of HIV care and support services to be funded under Part B. The Centers for Disease Control and Prevention expects federally-funded state HIV prevention programs to develop a comprehensive HIV prevention plan using an HIV Prevention Community Planning process. The State of Connecticut, Department of Public Health AIDS and Chronic Diseases Section has charged the CT HIV Planning Consortium with the development of a plan that describes the organization and delivery of HIV health care, prevention and support services.

## **A. OBJECTIVES TO ACHIEVE THE GOALS AND FULFILL STATE AND FEDERAL REQUIREMENT**

### **Structure**

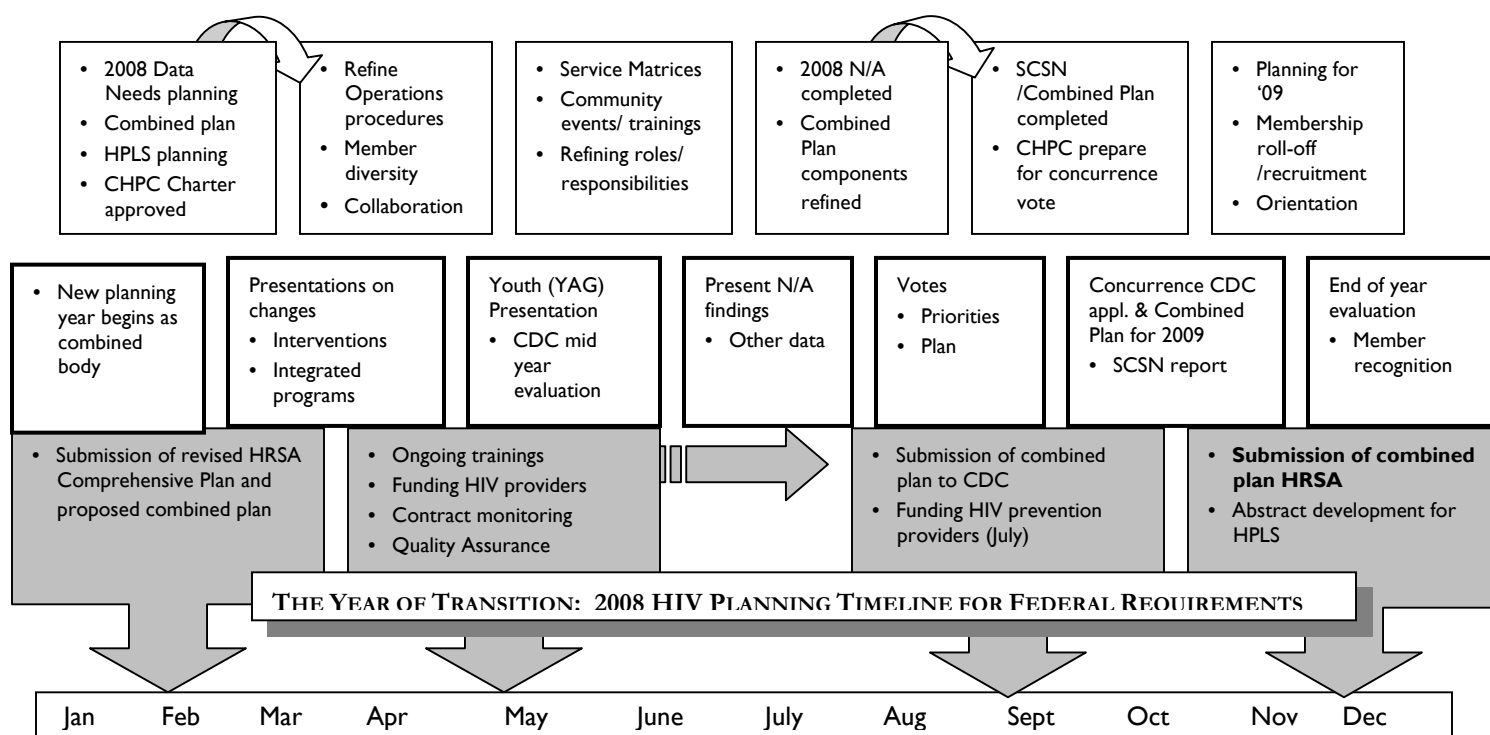
- Confirm operating structure, bylaws, membership roles and responsibilities, recruitment and retention processes of new planning body
- Confirm process to meet all federal requirements for the Human Resources Services Administration and the Centers for Disease Control and Prevention

<sup>6</sup> Approved August, 2007 Data Work Group & Integration of Care and Prevention Committee

<sup>7</sup> Approved June, 2007 Integration of Care and Prevention Committee

Unified Plan & Needs Assessment	
<ul style="list-style-type: none"> <li>▪ Develop and write one unified and integrated care and prevention plan</li> <li>▪ Conduct second statewide needs assessment and develop a Statewide Coordinated Statement of Need (SCSN)</li> <li>▪ Coordinate focus groups, one-on-one and key informant interviews and surveys to identify care and prevention needs, barriers, and service gaps</li> <li>▪ Coordinate with Youth Advisory Group (YAG) for needs, gaps, in prevention / care efforts targeting youth at risk</li> <li>▪ Conduct public forums/ focus groups to assess the impact of Ryan White funding cuts in the TGAs and statewide</li> <li>▪ Continue to consider emerging needs, the needs of those who are out of care or have unmet needs</li> <li>▪ Continue to monitor the CADAP formulary through the Statewide CADAP Advisory Group, add HIV and other medications as recommended by the group, and maintain the “no-wait list” status</li> <li>▪ Continue to review prevention outcomes relevant to funded Effective Behavioral Interventions (EBI) being implemented through statewide HIV prevention and care agencies</li> </ul>	
Continued coordination and collaboration	
<ul style="list-style-type: none"> <li>▪ Across Parts A, C, D and F to 1) assure services aren’t duplicated and individuals/ families affected and infected by HIV/AIDS receive quality care and prevention services in a culturally appropriate and accessible environment</li> <li>▪ Across all Ryan White Parts to develop standards of care, performance measures and assessment tool reflecting the medical case management model</li> </ul>	
Training / Information	
<ul style="list-style-type: none"> <li>▪ Continue to promote the on-going cross training of prevention and care staff, as well as supervisors and program managers through a series of continuing education workshops and seminars</li> <li>▪ Begin initial planning to implement informational sessions across the state to inform care, prevention and other relevant social service organizations on the integration of care &amp; prevention and promote the work of the CHPC</li> <li>▪ Develop / present an integration of care &amp; prevention workshop at the 2008 HIV Prevention Leadership Summit</li> </ul>	

The graphic below depicts the timeline to meet federal requirements in 2008.(See detailed version Section III.)



# SECTION I: WHERE ARE WE NOW?

## A. GEOGRAPHIC AREA

The geography of Connecticut, the location of the diverse client base and the services they need and are seeking, affect the way in which Connecticut's system of care is developed. This section briefly defines the geographic service area.

Connecticut (CT) is New England's second smallest state. Bordered by New York, Massachusetts and Rhode Island, CT is one of the smallest of the 50 states, and covers only 5,544 square miles. It is still 60 percent forested and boasts more than 90 state parks and 250 miles of the Long Island Sound. CT consists of eight counties, Hartford, Fairfield, Litchfield, Middlesex, New Haven, New London, Tolland and Windham, of which Hartford, New Haven and Fairfield contain 75% of the population. The three largest cities, Bridgeport, New Haven and Hartford, contain the highest percentage of Black and Hispanic populations, and approximately half of People Living with AIDS (PLWA) reside in these cities. Geographically, AIDS cases are concentrated in urban areas with the highest numbers in the three largest cities: Hartford, New Haven, and Bridgeport; but, 98% of Connecticut towns have at least one case

Planning across the state has occurred in a collaborative manner among the two Ryan White Part A Transitional Grant Areas (TGA), New Haven/Fairfield County and Hartford, other Ryan White Parts C and D, the Department of Public Health's (DPH), and through the Statewide Care Consortium (SWC). Part B funding is allocated to statewide contractors based on a competitive process and prioritized needs as defined in the Statewide Coordinated Statement of Need (SCSN). Responding to federal expectations that care and prevention be integrated and to directives established by the State DPH AIDS and Chronic Diseases Section, this Comprehensive Plan update for 2008 reflects updates as well as a description of the integration of the Statewide Care Consortium (SWC) and the HIV Prevention Community Planning Group (CPG) into a unified and comprehensive health care planning body – the Connecticut HIV Planning Consortium (CHPC).

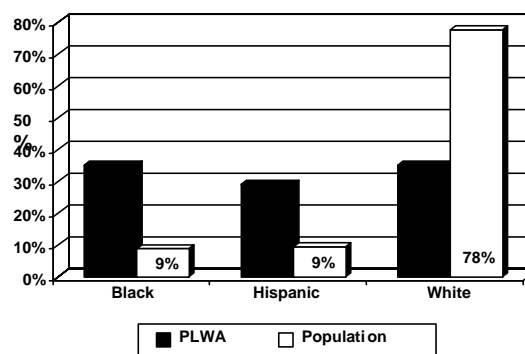
## B. EPIDEMIOLOGICAL PROFILE

### 1. CONNECTICUT'S PEOPLE

Connecticut has a diverse population, comprised of a rich blend of cultures and ethnic groups. Of the 3,405,565 residents in Connecticut, 75% reside in three of our eight counties, Fairfield, Hartford and New Haven. The three largest cities within these counties include the highest percentage of black (10.0-11.7%) and Hispanic (10.1-11.9%) residents, the highest percentage that speak a language other than English at home (17.7-23/9%), and the highest percentage of foreign born (9.0-16.9%). Overall, the majority of residents (81.6%) are white, 9.4% are Hispanic, 9.1 % black and .3% American Indian and less than 1% Native Hawaiian.<sup>8</sup> Alternatively, 77.5% are white (non-Hispanic) and 8.7% are black (non-Hispanic). The majority of Hispanics are Puerto Rican (60.7%), followed by Mexican (7.3%), Cuban (2.2%) and Others (29.7%).

Figure 1.

**CT Population by Race/Ethnicity Compared to People living with AIDS (PLWA)**



Source: CT DPH 2003

<sup>8</sup> Ibid – races can be Hispanic or non-Hispanic

Compared with national figures, Connecticut's residents are better educated; 84% or more hold a high school degree and maintain a per capita income that is 33% higher (\$28,766). Yet, nearly 8% of our residents live below the poverty line. Fairfield County has the highest per capita income (\$38,350) and Windham County has the lowest (\$20,443). These disparities translate into housing and healthcare problems and expressed need for Connecticut's people living with HIV/AIDS. Table 1 highlights the socio-economic status of Connecticut's residents by county contrasted by the total number of people living with AIDS through June 30, 2007.

Table 1: Connecticut, Counties by Race/Ethnicity <sup>9</sup> and Socio-economic Characteristics <sup>10</sup> 2000 CENSUS DATA															
Total PLWA through June 30, 2007 by County (CT DPH) <sup>11</sup>															
By Percent	Total PLWHA to 6/30/07	Population	White	Black or AA	AI& AN	Asian	NH& OPI	Other	Two or more races	Hisp or Latino	Foreign born	Other than English at home	High School or more	Persons below poverty line	Per capita income
Connecticut	10,470	3,405,565	81.6	9.1	0.3	2.4	<0.1	4.3	2.2	9.4	10.9	18.3	84.0	7.9	\$28,766
FAIRFIELD	2,761	882,567	79.3	10.0	0.2	3.3	<0.1	4.7	2.5	11.9	16.9	23.9	84.4	6.9	\$38,850
HARTFORD	3,294	857,183	76.9	11.7	0.2	2.4	<0.1	6.4	2.3	11.5	11.7	21.7	82.4	9.3	\$26,047
NEW HAVEN	3,192	824,008	79.4	11.3	0.2	2.3	<0.1	4.5	2.2	10.1	9.0	17.7	83.0	9.5	\$24,439
NEW LONDON	512	259,088	87.0	5.3	1.0	2.0	0.1	2.1	2.7	5.1	5.4	10.3	86.0	6.4	\$24,678
LITCHFIELD	185	182,193	95.8	1.1	0.2	1.2	<0.1	0.7	1.1	2.1	5.4	8.2	85.9	4.5	\$28,408
MIDDLESEX	219	155,071	98.4	4.4	0.2	1.6	<0.1	1.0	1.6	3.0	4.5	9.5	88.7	4.6	\$28,251
TOLLAND	107	136,364	92.3	2.7	0.2	2.3	<0.1	1.1	1.4	2.8	5.9	10.0	89.2	5.6	\$25,474
WINDHAM	200	109,091	91.3	1.9	0.5	0.8	<0.1	3.6	1.9	7.1	4.3	11.7	79.6	8.5	\$20,443
		Actual	Percent												Dollars

## 2. HIV/AIDS SURVEILLANCE

CT DPH surveillance system uses Census data to make calculations of incidence and prevalence in standard populations. Surveillance includes statewide information about cumulative AIDS cases, trends in AIDS cases by year of report, incidence of AIDS, trends in AIDS deaths, people living with AIDS, HIV (made reportable in 2002), and HIV in children. For each Community Planning Group and Ryan White region there are specific HIV/AIDS data. The data in this section are current through the end of 2002.<sup>12</sup> Methods to obtain data include the Behavioral Risk Factor Survey (BRFSS), a random, weighted telephone survey conducted annually in Connecticut. Several questions about HIV are included in the survey and offer insight into the attitudes about HIV in the general population.

Newly available surveillance data includes Sexually Transmitted Diseases Surveillance (STD) and Viral Hepatitis Surveillance. STD information is relevant to HIV prevention because STDs can be transmitted in the same manner as HIV and are likely to be diagnosed and reported much sooner after infection than HIV. More importantly this is emphasized because of the high proportion of recent syphilis cases associated with

<sup>9</sup> African American, American Indian, Native Hawaiian, Other Pacific Islander, Hispanic

<sup>10</sup> 2000 Census Data

<sup>11</sup> Connecticut Department of Public Health, Surveillance

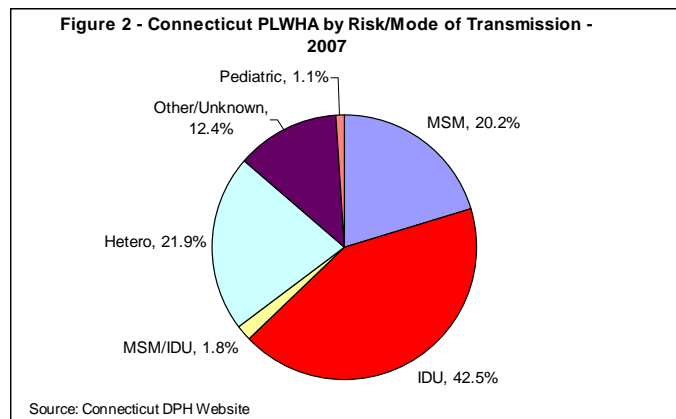
<sup>12</sup> The CDC has developed *draft* guidance for the production of state Epidemiological Profiles. In the most recent version of CDC guidance, it is recommended that state Epidemiological Profiles provide information for both Community Planning Group Regions and Ryan White Eligible Metropolitan Areas.

MSM. This marks the first year in which this type of information is considered in the Statewide Coordinated Statement of Need (SCSN).

## HIV Infection in Adults

In 2002, HIV infection in adults became reportable.<sup>13</sup> It can be expected, on average, that persons reported with HIV who do not meet the AIDS case definition, are at an earlier stage of disease progression than persons reported with AIDS.

During 2006, 926 HIV cases were reported. 2006 HIV cases in comparison with AIDS cases, were more likely to be female (HIV 39% vs. AIDS 36%), White (37% vs. 28%), and younger (HIV: 25.6% 20-29 and 11.3% 50+ vs. AIDS: 10.9% 20-29 and 21.4% 50+), and were more likely to be initially reported without risk information (31% vs. 29%)<sup>14</sup>. An additional year or two of HIV reporting



will be needed to substantiate these findings and establish trends.

<b>Table 2: Cumulative AIDS Case by Race, Gender, Age, and Exposure Category 1980-2007</b>		
	totals	% of total
<b>A. Race</b>		
White	5,571	36.8%
Black	5,491	36.3%
Hispanic	3,973	26.2%
Other	105	0.7%
<b>B. Gender</b>		
Male	10,868	71.8%
Female	4,272	28.2%
<b>C. Age at diagnosis</b>		
Less than 13 years	182	1.2%
13 – 20 years	76	.5%
20 – 29 years	1,938	12.8%
30-39 years	6,389	42.2%
40 – 49 years	4,603	30.4%
50+ years	1,953	12.9%
<b>D. Exposure Category</b>		
Injection drug users	7370	48.7%
Heterosexuals	2738	18.1%
Men who have sex w/ men	3338	22.0%
Men who have sex w/ men & inject drugs	464	3.1%
Other/Unknown	1020	6.7%
Pediatric	210	1.4%

## Cumulative AIDS Cases

Since 1981, 14,917 cases of AIDS have been reported (through December 31, 2006). Of these, 7,607 (50.1%) have died and 7,310 are living with AIDS. Table 2 depicts the cumulative AIDS cases by race, gender, age and exposure category<sup>15</sup>.

## Disparities

- While 8.7% of the population is black and 9.4% is Hispanic, 36.3% of AIDS cases are black and 26.2% are Hispanic.<sup>16</sup>
- The predominant risk group among black and Hispanic males is IDU at 60% and 63% respectively.
- Hispanic youth have a higher percentage of cases than other groups by race.
- The percentage of male cases is at 79% in the over fifty age group.

<sup>13</sup> Persons testing anonymously at one of Connecticut's HIV Counseling and Testing Sites are not counted, as they cannot be deduplicated and are likely to eventually get a non-anonymous HIV test and be reported then. Persons who tested positive prior to 2002 are not reportable. Reported HIV cases are entered into the same registry as AIDS cases. Various demographic and medical information is collected about each case of HIV or AIDS including: laboratory test dates, sex, race, town of residence, exposure category, AIDS indicator diseases, treatment status, pregnancy status, and provider information.

<sup>14</sup> Connecticut Department of Public Health. "Epidemiological Profile of HIV/AIDS in Connecticut." 2007

<sup>15</sup> Ibid

<sup>16</sup> CT DPH Website Statistics through June 2007.

## People Living with AIDS (PLWHA)

Table 3 depicts the number of people living with HIV/AIDS as of June 30, 2007 by race, gender, age and exposure category.

- Sex – In all age groups the majority of cases are male.
- Race – The percentage of cases that are Hispanic decreases with increased age and the percentage of white cases increases with age. The percentage black remains approximately constant in all the age groups.
- Risk - IDU risk is highest age groups over 30, while MSM is the highest risk for the 20-29 group.<sup>17</sup>

## Sexually Transmitted Diseases and Viral Hepatitis

Information from the STD and viral hepatitis surveillance systems also provide insight into high-risk behavior that can potentially lead to HIV infection. High numbers of chlamydia and gonorrhea cases in older teens and younger adults have been reported in recent years suggesting the persistence of unsafe sexual activity. Similarly, the connection between MSM and both syphilis and hepatitis A in Connecticut, and nationally, suggests resurgence in high-risk behavior in MSM that could lead to increases in HIV infection.

## HIV Surveillance

Although the data shown is rudimentary, it is of interest to HIV prevention and care because, in Connecticut, IDU is the predominant risk group for both hepatitis C and HIV. Indeed, co-infection with HIV and hepatitis C is an emerging care issue in Connecticut. AIDS has been on the list of reportable diseases since the early 1980's.<sup>18</sup> However, HIV infection has only been reportable in adults ( $\geq 13$  years of age) since January 2002. Prior to 2002, HIV was reportable only in children and persons with co-infection with tuberculosis.<sup>19</sup>

Viral load test results are now reportable. Laboratories are required to report HIV viral load tests with the viral load measurement, including those that have no detectable viral load. The purpose of viral load reporting is to provide population based information about the interval between initial testing and entry into care for all HIV infected persons, provide information about consistency and effectiveness of care, determine whether there are subgroups of persons with longer delays and/or consistent care, and to track changes over time. The CT DPH provides regular surveillance updates via email communication and at the monthly HIV/AIDS planning body meetings. The table below shows the most recent report.

**Table 3: PLWHA as of 6/30/07 by Race, Gender, Age, and Exposure Category**

	PLWA % of total
<b>A. Race</b>	
White	35.0%
Black	31.1%
Hispanic	32.5%
Other	1.3%
<b>E. Gender</b>	
Male	65.9%
Female	34.1%
<b>F. Age</b>	
Less than 13 years	.2%
13 – 19 years	.9%
20 – 29 years	4.7%
30-39 years	17.0%
40 – 49 years	41.8%
50+ years	35.4%
<b>G. Exposure Category</b>	
Injection drug users	42.5%
Heterosexuals	21.9%
Men who have sex with men	20.2%
Men who have sex with men and inject drugs	1.8%
Pediatric	1.1%
Other / Unknown	12.4%

<sup>17</sup> Connecticut Department of Public Health. "Epidemiological Profile of HIV/AIDS in Connecticut." 2007

<sup>18</sup> The AIDS case definition consists of either HIV positive with a low CD4-positive cell count (below 200 cells/microliter or less than 14% of total lymphocytes), or HIV positive and a diagnosis with one of several opportunistic infections or conditions (for example, *pneumocystis carinii* pneumonia or cervical carcinoma). AIDS cases are reported to the Department of Public Health by diagnosing physicians and laboratories (low CD4 counts). For each case of AIDS reported, the reporting physician or surveillance staff complete a case report form. The Department of Public Health maintains a computerized registry of AIDS cases.

<sup>19</sup> HIV is reported when an individual is confirmed HIV positive by Western Blot or other confirmatory test.

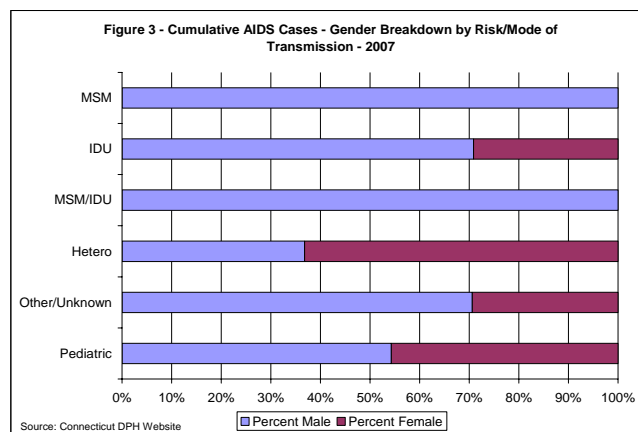
HIV and AIDS cases by initial source of report<sup>1</sup>,  
Connecticut, January – September 10, 2007.

	AIDS		HIV		Total	
	N	%	N	%	N	%
Private physician <sup>2</sup>	36	12%	53	8%	89	9%
ICD-9 code review <sup>3</sup>	32	10%	100	16%	132	14%
HIV C&T sites <sup>4</sup>	4	1%	47	7%	51	5%
Pediatric clinic	0	0%	0	0%	0	0%
Corrections	3	1%	8	1%	11	1%
Laboratory reports <sup>5</sup>	176	57%	80	12%	256	27%
Out of state <sup>6</sup>	1	0%	0	0%	1	0%
Providers <sup>7</sup>	1	0%	0	0%	1	0%
VL reports <sup>8</sup>	56	18%	356	55%	412	43%
Total	309	100%	644	100%	953	100%

1. Source of report is the first indication of a case. Cases can be reported from multiple sources.
2. Physicians report using the HIV/AIDS Confidential Case Report Form.
3. DPH staff request specific HIV/AIDS related medical records for review
4. Publicly funded HIV counseling and testing sites.
5. Laboratory reports of confirmed Western blots and low CD4 (<200 or <14%).
6. Each state surveillance systems report cases residing in other states to the appropriate state.
7. DPH staff contact providers to review patient/client lists for reporting completeness.
8. Viral load laboratory reports.

## Risk Groups

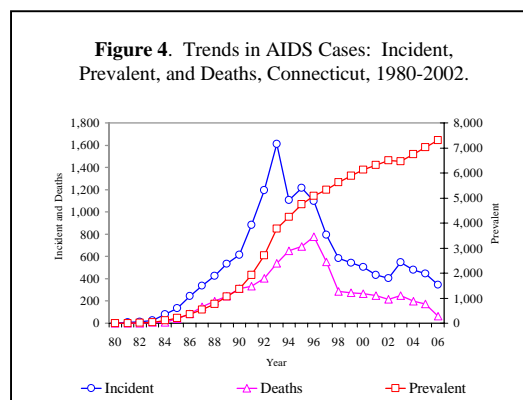
Figure 3 to the left depicts the predominant risk groups among males and females. While the majority of white males are MSM (52.9%) and a minority are IDU (28.5%), among black and Hispanic males the proportions are approximately reversed with 16% MSM and 61% IDU. White and black females are more likely to be IDU and Hispanic females are more likely to be associated with heterosexual transmission. Of the 3,338 AIDS cases reported with MSM risk, 68.8% were white, 17.8% were black, 12.6% were Hispanic. Among non-MSM males with risk known to be either IDU or heterosexual exposure 29-63% are IDU and 6-12% are heterosexual depending on race. Among females with known risk 44-56% were IDU and 33-47% heterosexual depending on race.



## 3. EPIDEMIOLOGICAL TRENDS

Connecticut ranks 9<sup>th</sup> among the states in the number of AIDS cases per 100,000 with a staggering estimated amount of 15,000 cumulative AIDS cases for Connecticut residents currently infected with HIV. In 2001, 1.5% of the AIDS cases reported in the U.S. were among Connecticut residents. Although the annual number of AIDS cases reported in Connecticut has declined dramatically from 1,763 in 1993 to a plateau of about 600 per year since 1998, the number of PLWA has increased.

In Connecticut, AIDS has disproportionately affected specific demographic and behavioral risk groups including males (72% of all cases reported), blacks (36%), Hispanics (26%), injection drug users (49%), and men who have sex with men (22%). The percentage of reported



AIDS cases in women has increased from 25% in 1993 to 29% of cases reported in 2007. There has also been a gradual shift in age distribution to older age groups except in the Hispanic population. Heterosexual transmission has increased from 15% of cases in 1993 to 18% in 2007. Geographically, AIDS cases are concentrated in urban areas with the highest numbers in the three largest cities: Hartford, New Haven, and Bridgeport; but, 98% of Connecticut towns have at least one case.

**Figure 4** shows the gradual trends in Connecticut AIDS cases from 1980 – 2006. The first reported AIDS case was in 1981. The maximum number of AIDS cases (1,759) was reported in 1993. The trend in reported AIDS cases has leveled off at about 600 per year for the past five years (range 540-691). Considered in this plan are the following trends of note over the past 10 years:

- **Increase in female cases:** The percentage of cases that are female has increased about 5-10%.
- **Increase Hispanic cases:** The percentage of new cases that are Hispanic has increased from about 26% to about 42%.
- **Decrease in black cases:** The percentage of black cases has decreased from 40% to about 26%.
- **Heterosexual increase:** Heterosexual transmission has increased from 16% in 1995 to 19% in 2006.
- **Slight decline in IDU and MSM:** Recent trends (to 2006) show a decline in percentage of cases that are IDU although it remains predominant (about 34% in 2006) The percentage of cases that are MSM has decreased from about 20% in 2000 to 17 in 2006%.<sup>20</sup>
- **Increase in new diagnoses at later age:** Trends by age group suggest a gradual increase in the age of newly diagnosed cases. While the percentage of cases in the 20-29 and 30-39 age groups has been decreasing, the percentage of cases that are in the 40-49 and 50+ age groups has been increasing. This figure has changed approximately 10 percentage points over the past ten years. This shift in age distribution could be due to delay in AIDS diagnosis because of successful treatment, a trend to older age at HIV infection, or a combination of the two.

#### 4. CONNECTICUT'S RESPONSE TO HIV

On August 18, 1990, Congress enacted Public Law 101-381 known as the Ryan White Comprehensive AIDS Resources Emergency Act, or the CARE Act. This legislation was re-authorized in both 1996 and 2000, and was recently reauthorized in December 2006 as "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006," or "Ryan White." The Ryan White Program is the single largest federal program designed specifically for people with HIV/AIDS and is intended to help communities, States, and directly funded public and private providers increase the access to care for underserved populations and to improve the quality of life for those affected by the HIV epidemic. During the first fiscal year of the CARE Act in 1991, 16 areas of the nation qualified for Title I (now Part A) funding for emergency resources to localities that were disproportionately affected by HIV/AIDS. New Haven and Fairfield Counties first qualified to receive Part A funds in 1993 and Hartford in 1994. In Connecticut, the DPH has applied for and received Ryan White Part B funds for 16 years from the U.S. Department of Health and Human Services, Health Resources Administration (HRSA). This funding also includes support of the Connecticut AIDS Drug Assistance Program (CADAP) administered through a memorandum of agreement with the State Department of Social Services (DSS).

**The Ryan White Modernization Act of 2006.** The 2006 reauthorization not only brought changes to the way CT provides services, but also changed the make-up of the state's two former Eligible Metropolitan Areas (EMA) – New Haven/Fairfield County and the Greater Hartford EMA (including Hartford, Tolland and Middlesex Counties). Part A now funds cities and communities as EMAs who report a cumulative total

<sup>20</sup> CT DPH Website. Risk group data after 2000 should be interpreted cautiously due to a high percentage of cases with "no reported risk" (15.6% in 2000).

of more than 2,000 AIDS cases over the most recent five year period, and other localities as Transitional Grant Areas (TGA), who report 1,000-1,999 AIDS cases over the most recent five year period. As a result of the new legislation, Connecticut's two EMAs were designated as TGAs and received an adjustment in funding. In addition, the reauthorization added the requirement that at least 75% of Parts A through C funds (formerly Titles I, II and III) had to be allocated to "core medical services" with the accompanying addition of Medical Case Management to the core service matrix. CT's TGAs and Part B had to reconfigure funding priorities based on HRSA's new thirteen core service list, and reduce funding for non-core areas such as transportation, housing, emergency financial assistance and food. In addition, the DPH has been collaborating extensively with Parts A-D to develop a definition for Medical Case Management that would be acceptable and applicable both statewide, locally and regionally. HRSA has also provided technical assistance to both DPH and the TGAs in defining a medical case management model and in creating a broader base of collaboration and coordination to meet the needs of people living with HIV/AIDS in the service delivery areas.

**The Health Care and Support Services Unit (HCSS)** of the DPH AIDS and Chronic Diseases Section is responsible for the oversight of Ryan White Part B and Minority AIDS Initiative (Part B) funding. Previously, to address disparities in HIV care, access and services, DPH funded programs through 9 local consortia and state operated programs and initiatives. An HIV Care Consortium is defined as "an association of one or more public and one or more nonprofit private or private for-profit providers or organizations if such entities are the only available providers of quality HIV care in the area, health and support service providers and community based organizations operating within areas determined by the State to be most affected by HIV disease."<sup>21</sup> These local consortia were each required to complete a yearly plan identifying service priorities including a description of organizations and services being provided in their catchment area, identification of emerging needs and populations, barriers to services, and participation in a needs assessment survey. The process, although burdensome for consortia, assisted DPH with further planning, resource allocation and delivery of health and support services for the state. Because the Statewide Consortium reassessed and revised its role to serve as the advisor to DPH and the TGAs on the provision of effective planning and the promotion, development, coordination and administration of HIV/AIDS health care and support services, the local consortia were no longer contractually required in 2004.

**The Connecticut Statewide HIV Care Consortium (SWC)** was formed in 1994 as a collaborative endeavor between the state of Connecticut and New Haven/Fairfield Ryan White Title I (now Part A) to deal with policy, service needs, consumer empowerment and the need for interagency coordination at the regional and statewide level. In 1996, the Greater Hartford Title I (Part A) area voted to join the Consortium, thus further broadening the collaborative body. The SWC represents a diverse membership reflective of the epidemic in CT and includes consumers and appointed representatives from Parts A-F, as well as other statewide organizations and governmental agencies. It is responsible for developing the SCSN and an integrated care and prevention plan, and establishing a collaborative process to identify unmet need. The SWC will merge with the HIV Prevention CPG in October 2007 to form CT's comprehensive health care planning body – the CHPC.

**Prevention:** The DPH issued an RFP in 2004 for all state and federally funded HIV prevention services. Subsequently, the HIV prevention plan provided valuable information on prevention needs, and the prevention priorities set by the CPG. The updated 2007 SCSN, which included prevention information, provided valuable information on prevention needs and service access barriers. Applicants used this information to tailor proposed prevention interventions. Funding priority was given to applicants that proposed targeting priority populations identified by CPG and to applicants that proposed using Effective Behavioral Interventions to reach them

**DPH AIDS Program Structure:** The DPH HIV/AIDS Programs are organized into three units. The Health Care and Support Services Unit (HCSS) oversees care programs and services for people infected or affected by HIV. The HIV Prevention Unit oversees prevention services for people infected or at risk of

<sup>21</sup> Ryan White Care Act amended Section 2513(a).

infection. The Surveillance Unit oversees the data that is collected on HIV and AIDS in Connecticut and is responsible for producing the state's Epidemiological Profile.

**Accomplishments FY 2006:** Connecticut has made major strides in planning and the provision of services over the 16 years of Ryan White federal funding. Major accomplishments in FY 2006 - 2007 include:

- Addition of two new HIV antiretrovirals to CT's ADAP (Altripla and Prezista), bringing the total formulary to 214, with a no-wait list.
- Expansion of HIV Medication Adherence services to counties identified as needing these services and state funding of eleven Medication Adherence Programs (MAP) in FY 2007-08
- Collaboration with CPG on prevention efforts and planning for integration of plans and planning bodies
- Provision of regular updates on Viral Load Reporting and surveillance via statewide distribution list and public meetings
- Update to the SCSN, including information from the 2006 out-of-care survey
- Implementation of cross-trainings for both Care and Prevention case managers (ICP Capacity Building Training Series and Fundamentals of Case Management)
- Creation of a comprehensive HIV/AIDS resource inventory through 2-1-1 Infoline services
- Creation and dissemination of four HIV/AIDS Planning News and Notes quarterly newsletter
- Creation and implementation of a collaborative out-of care survey with the two Parts A, B and CPG
- Revision and update of the Statewide Coordinated Statement of Need
- Creation of a process to fully integrate care and prevention planning by combining the two planning bodies by October 2007
- Recognition by CDC at the HPLS conference as having a notable process the unify planning bodies, that was inclusive, thoughtful, worthy of replication
- Coordination of a collaborative process to define Medical Case Management and begin working on standards of care
- Coordination of combined meetings with the Community Planning Group and Statewide Consortium to plan the integration of the two planning bodies and to address review and approve the Statewide Coordinated Statement of Need

This document is the transition plan to complete the integration by combining both the care and prevention plans and submitting them as one unified plan in 2009 to both CDC and HRSA

### **HIV Service Delivery System**

Connecticut provides assistance to people living with HIV or AIDS (PLWA) and their families through HIV/AIDS service organizations. Services include support for, but may not be limited to the following: medical case management, out-patient, dental, mental health, nutritional therapy, substance abuse, specialty care prescriptions, transportation, housing, food/meals, and specific emergency financial assistance. PLWHA can access medical and traditional case management services throughout Connecticut for assistance with the health care and supportive services they need at no cost. Statewide HIV/AIDS programs include AIDS Drug Assistance Program (ADAP), AIDS Health Insurance Assistance, the Pediatric AIDS Program, Transitional Linkage into the Community (TLC), and Connecticut Mental Health Services for Children Affected by HIV.

### **How We Collect Data**

Connecticut laws require the DPH to maintain a list of reportable diseases. The list includes approximately 60 diseases and conditions of public health importance. AIDS was added to the list in 1982 and HIV in adults was added in 2002. Cases are reported by patient name to permit de-duplication of reports for the same individual. Physicians who diagnose HIV and AIDS are required to report cases to the state. All laboratories performing Western Blot, Viral Load, and HIV Antibody tests are also required to report cases to the state. HIV positive individuals are also researched via patient lists received from medical facilities. All potential cases are followed up via phone, mail, or by medical chart reviews. Various demographic and medical information is collected about each case of HIV or AIDS including laboratory test dates, sex, race, town of residence, exposure category, AIDS indicator diseases, treatment status, pregnancy status, and provider

information. Connecticut law prohibits release of this information to unauthorized persons. Only authorized persons within the CT DPH have access to this information. Only de-identified information is reported to CDC (no names or street addresses). Information is analyzed and disseminated in aggregate only. The year of report is based on the date that the case was first reported to the DPH. However, AIDS cases may have been diagnosed in years prior to the year in which they were reported. In 2002, for example, the median delay in reporting of AIDS cases was two months with 66% of cases reported within 4 months after diagnosis and 78% reported by 12 months. Reporting delay results in an undercount of recently diagnosed cases.

Part A has been performing data collection through focus groups, one on one interviews, provider surveys, and phone interviews. The AIDS and Chronic Disease Section also obtains data through other methods such as surveys, evaluations, and specific studies all of which provide information that enables the state to update the SCSN. Data collection in FY 2006 involved a collaborative effort with Part A and the CPG.

### C. ASSESSED NEEDS OF THE AFFECTED POPULATION

**Process:** Service priorities throughout the state are identified regionally, through Part A partners in Hartford and New Haven/Fairfield counties, the SWC, and are specified on the updated 2007 SCSN.

The Ryan White Treatment Modernization Act of 2006 made a significant impact on service priorities including the various needs assessments used in establishing the care priorities. Core Services were changed as a result of the Modernization Act. These changes were reflected in the revised and updated SCSN. New recommendations were written to specifically address those changes.

The SCSN incorporates HIV and AIDS surveillance data, data from the 2005 Statewide Needs Assessment process, and additional data<sup>22</sup> provided by planning bodies, other community based organizations, and governmental agencies. HIV/AIDS surveillance data is collected by the Connecticut State Department of Public Health. The 2005 Statewide Needs Assessment data is based on a survey administered to HIV+ in-care individuals across the state. The method involved statewide analysis and analysis by the three major geographic areas: the New Haven-Fairfield TGA, the Hartford TGA and a region consisting of Litchfield, Tolland, Windham and New London counties. Data on out-of-care HIV+ individuals was collected via a statewide out-of-care survey process similar in nature to the in-care survey process. The SCSN takes into consideration the following HRSA recommended data:

**Data on HIV Cases and AIDS Cases** is provided through the CT HIV/AIDS Epidemiological Report.

**Needs of People Living with HIV (PLWH)** are assessed through the needs assessment results, information provided by planning partners such as CPG focus groups, surveys, and key informant interviews, Youth Advisory Group interviews and focus groups, and supplementary data from both Title I EMAs and addressed through other mechanisms such as funding and quality assurance, among others.

**Existing available services** – the CPG compiles a service matrix of prevention providers, many of which also provide care services. A list of all funded and private providers was compiled by the group to determine the number in each region and to estimate client numbers served by those providers.<sup>23</sup> In creating the inventory of resources, the partners considered the total Ryan White resources in the State, both in the amount of funds and the services being supported by these funds

**Unmet needs and service gaps.** The unmet needs estimate has been readdressed with the assistance of Mosaica<sup>24</sup>. Although technical assistance was provided and a methodology proposed, the state was unable to obtain all the recommended data. Therefore, the SCSN provides an explanation of the significant limitations

<sup>22</sup> Additional data refers to: focus group information, surveys conducted, and individual interviews. These were provided by the CPG, community organizations, and Title I planning bodies.

<sup>23</sup> [Note: A recent partnership with 211 Infoline (June 2006) allowed for the development of a service guide and comprehensive list of all services available to PLWH in the state of Connecticut. This list includes contact information, addresses, and hours of operation. The service list will be updated and maintained on a regular basis by 211 Infoline.]

<sup>24</sup> The state of CT requested technical assistance from HRSA to assist in creating a HRSA approved method for estimating Unmet need. Mosaica is the Federal technical assistance provider for Ryan White funded programs.

to the revised and updated estimate for unmet need included in this document. Further discussion of this occurs on page 10.

- Service gaps were identified by the in-care needs assessment.
- Also updated in this version is the out-of-care survey information. The process entailed attempted focus groups, then a determination of an out-of-care survey process. The methodology employed has definite limitations, which are discussed on page 29.

Given the available resources, the methodology employed is the best collective effort of the planning group. As in any assessment, there are limitations that must be considered as discussed in the relevant sections following.

CPG and Parts A and B collaborated on a statewide out of care survey instrument and the implementation of the survey, and on a process to determine unmet need.

## 1. DATA SOURCES

*Needs Assessments:* Through Needs Assessments conducted in collaboration with the Part A partners in Hartford and New Haven/Fairfield counties and the CPG people living with HIV/AIDS were surveyed to confirm how services are being used, and to identify and document the primary unmet needs. This year, the Consortium provided venues in which consumers could be surveyed to assess their overall service needs and specific categories (e.g., medication adherence, and issues specific to the Latino population). A new needs assessment survey will be conducted in 2008. Planning for this survey will begin in January 2008. This update reports on the changes made during the 2006-2007 fiscal year and activities related to the updated SCSN.(see SCSN p.37)

The SCSN was originally submitted in January 2005. The SCSN was developed through a collaborative process involving Ryan White Parts and providers of HIV/AIDS services in care and prevention both having a focus on the HIV+ population. The SCSN was presented and shared at two public meetings in January 2005. Input from those meetings was considered in the final development of the full report. In October 2006, the Health Resources and Services Administration (HRSA) requested that the DPH re-issue the SCSN in its current form to representatives of all Ryan White Parts and Part F Administrators including Administrators of the AIDS Education and Training Centers, the Dental Reimbursement Program, and Special Projects of National Significance Demonstration Grants operating within Connecticut. The representatives provided comment and input with DPH submitting a revised SCSN based on the comment and input. The reissued document incorporates information produced by ongoing efforts of our planning bodies. Specifically, at the end of November 2006, DPH would issue to representatives an updated SCSN that: a) incorporates the work (to date) in areas such as unmet need, comprehensive resource inventory, and the out-of-care survey, and b) addresses specific suggestions and recommendations identified by HRSA. The current SCSN is based primarily on the 2005 Statewide Needs Assessment, the 2006 out-of-care survey, and the state of Connecticut Epidemiological Profile.

*Other Data:* Through compilation of other data (e.g., other funding, service utilization, progressive research), the Consortium continues to process information to identify and understand the outstanding HIV care needs and, in turn, the gaps in care and prevention. Studies conducted over the past year include out of care, focus groups through CPG, and medical case management across Ryan White Parts A, B, C, and D.

*Limitations of data:* These data are a compilation of formative research efforts conducted over a period of three or more years. Most of the data sources are in no way intended to be portrayed as scientific, but are qualitative measures that serve as an initial gauge of public and professional perceptions, knowledge and behavior. These qualitative measures are incorporated in our assessment of HIV service gaps, and will be further expanded and refined over time. The out of care surveys although providing a picture of the out of care population in Connecticut are not statistically significant and should be viewed as “somewhat representative” of the out of care population.

## Care and Prevention Coordination

The importance of connecting prevention activities with care and its impact on the care system has been recognized by funders, providers, planners and consumers alike. More importantly, the focus by both care and prevention is now on HIV+ individuals. Efforts to improve coordination with other services primarily involve linkages with HIV prevention. Part B has embarked upon a planning process to integrate care and prevention systems. CPG, Part A Planning Councils and Part B service providers have consistently indicated the need to have outreach, care and prevention systems work together to get people tested and into care. During the planning process for the Comprehensive HIV Care and Prevention Plan 2004-2007, the collaborators agreed that the prevention of secondary infection for persons who are already infected with HIV is of primary importance, and have identified that counseling and testing, prevention outreach, and health education and risk reduction services are the primary areas where prevention and care efforts overlap and require a collaborative approach. [Please see Connecticut's Comprehensive HIV Care and Prevention Plan 2004-2007 for more detail.]

Current areas of collaboration between care and prevention include:

- Needs Assessment
- Quality Assurance
- Information/data sharing
- Resource Inventory
- Out-of-care surveys
- Gap analysis
- Cross training/education and capacity building in prevention and care

Other areas of collaboration underway include:

- Membership – sharing the responsibilities of recruiting and retaining members
- Monitoring the epidemic – collaboratively developing data collection methods that include both care and prevention
- Setting priorities for care and prevention

Recognizing that HRSA and the U.S. Centers for Disease Control and Prevention (CDC) have expectations that care and prevention will be integrated, the comprehensive plan and this statement of need both acknowledge that effective prevention means full engagement of the care community. Incorporated within the Plan and the SCSN is a process that will reflect the shared vision of both care and prevention providers. These are detailed in the Comprehensive HIV Care and Prevention Plan. Furthermore, the planning bodies identified the need for an ideal continuum of care that is meant to work within a unified system of care and prevention. This SCSN update represents a second major step in the collaborative effort among Ryan White and Prevention funded planning bodies, providers and clients to accomplish the goals set forth in the Comprehensive Plan. These goals are:

- To create an ideal system of care and prevention that creatively responds to the needs of the target population;
- To respond to the new directives;
- To decrease the number of infections;
- To create appropriate links for a comprehensive continuum of care that increases efficiency and avoids duplication of effort;
- To strengthen care and prevention efforts;
- To better identify and address the statewide unmet need; and f) to maximize resources.

The ICP, formerly the Ad Hoc Committee developed, with input from the SWC, the CPG and public hearings, objectives and strategies designed to create and work within a unified system of care and prevention.

***a. Data from New Haven / Fairfield and Hartford Part A TGAs***

**Epidemiology (Epi)** Connecticut began HIV reporting for the first time in 2002. The updated plan includes information provided by the first year of HIV data.<sup>25</sup>

**2003 Needs Assessment** Information was collected from 556 individuals who are living with HIV/AIDS and in care and another 156 individuals living with HIV/AIDS who are not in care. A major assessment conducted by the New Haven Fairfield Planning Council Evaluation and Assessment Committee in FY2002 in collaboration with the Hartford and DPH, with analysis and results returned in 2003. The needs of individuals that are in-care (have seen a medical provider in the last six months) and individuals that are out of care (have not seen a medical provider in the last six months) were assessed. Information identified included most often accessed and unmet service needs, and more detailed information on at-risk behaviors, health status / health history, medical care / medical services, and several special topic areas including current drug users, recently homeless, recently incarcerated, women and children, and individuals living in poverty.

**2005 Needs Assessment** Through Needs Assessments conducted in collaboration with the Part A partners in Hartford and New Haven/Fairfield counties, Part B statewide and the CPG people living with HIV/AIDS were surveyed to confirm how services are being used, and to identify and document the primary unmet needs.

**Hartford Youth HIV Information and Linkage (HYHIL) Project** Identification of HIV positive youth who do not know their status and/or are not in care.

**2006 NH/FF Comprehensive Chart Review** - The comprehensive chart review conducted on 100% of 'In Care' client charts of six Core HRSA funded services demonstrated that focused efforts occurred by these providers to attach clients to primary medical care or document where they do receive care (even if in private sector, veterans healthcare, etc).

**2006 Out of Care Surveys** conducted statewide in New Haven / Fairfield TGA, Hartford TGA and the Windham, New London, and Litchfield counties.

**2006 Updated/Revised Statewide Coordinated Statement of Need (SCSN)**

***b. Data from Connecticut HIV Prevention Community Planning Group (CPG)***

**Emerging populations survey** also presented interesting findings. Services identified as needed but not available included educational workshops on safer sex and how to access basic HIV services. Barriers identified to accessing services included fear of being judged and lack of transportation.

**2004 Community Services Assessment Update** In 2002, the CPG's Community Services Assessment Committee decided to build on the most recent comprehensive needs assessment and gather information about emerging populations in Connecticut. To that end, the update discussed information obtained regarding the HIV risks and prevention needs of two of the three emerging populations identified by the 2002-2004 comprehensive plan: (a) individuals over fifty and (b) migrant farm workers. Because of difficulties encountered in scheduling focus groups within the Department of Corrections, the focus groups targeting incarcerated populations were not included in the 2004 Update.

<sup>25</sup> Please note that gaps are based on AIDS data as only one year of HIV data is currently available in CT. Existing HIV data is incorporated as appropriate with the admonition that it may still be too early to judge the reliability of HIV data or calculate trends.

**Focus groups** were conducted from May through July 2007 with more than 8 individuals in the Transgender population to determine any issues that would keep them from receiving prevention services. Discussion topics included the following:

- Awareness of existing HIV and Sexually Transmitted Disease (STD) services
- HIV/STD services participants would like to see implemented
- Barriers to accessing existing services
- Risk issues and concerns
- Where participants currently get HIV/STD information
- Where participants would like to get HIV/STD information

**Key informant Interviews** were also conducted with members of the deaf and hard of hearing population adults, and youth to gain input on factors that may put them at particular risk. Interview questions included specific concerns, awareness of services and where they currently get information related to HIV/STD.

## 2. GAPS IN HIV CARE AND IMPACT OF FUNDING CUTS

The following gaps in care identified by the New Haven/Fairfield and Hartford Part A TGAs and CPG in conjunction with the Needs Assessment and supplemental data were used to determine the Statewide Gaps.

### *a. New Haven/Fairfield Part A TGA Service Gaps*

The New Haven Fairfield TGA conducted an **Out of Care study** in 2007 in which over 10% of respondents report gaps in Oral Health/Dental Care and Mental Health services (need service and could not get).

The quality management full **population-based chart review** conducted in the summer of 2006 indicated that mental health is the most disparate service specific to monolingual clients (Spanish speaking only), with 35% of overall 'In Care' clients reporting Spanish as their primary language and 15% of this group reporting monolingual comprehension.

*Estimated levels of service gaps:* The level of service 'gaps' or "need services but could not obtain" was assessed in the 2006 In Care Needs Assessment. The table below displays the aggregate of top gaps with distinctions for females, males, African Americans, Latino, Whites, White MSM, MSM of Color, Injection Drug Users and Incarcerated/Recently Released.

Table 4. Rank of Top 5 Service Gaps from 2006 'In Care' Needs Assessment

Service	Females	Males	AA	Latino	White	White MSM	MSM of Color	IDU	IRR*
Dental Care	1	1	1	1	1	1	1	2	1
EFA*	2	2	3	2	2	2	4	3	3
Housing Services	3	2	2	--	3	5	2	1	2
Mental Health	5	3	4	4	5	3	3	6	6
Food	4	5	3	5	6	6	2	5	5
Outreach	4	4	5	3	4	4	5	4	4

(Source: 2006 'In Care' Needs Assessment: \*IRR – Incarcerated/Recently Released: \* EFA-Emergency Financial Assistance)

Efforts to address the needs of special populations including the racial/ethnic groups, women of color, monolingual clients, and specific exposure groups include assessing their needs (both for In Care and Out of Care clients), which services would most help individuals enter care or maintain care status, and details regarding customized continuums of care or pathways towards primary medical care by special populations. The FY 2007 Implementation Plan builds on the success of the TGA to reach disproportionately affected communities.

**Medical care needs (core services and other support services** were assessed by service category for all respondents of the ‘In Care’ Needs Assessment.

**Table 5. Service Category Need Ranking, 2005**

		TOP 5 SERVICE NEEDS					
		Dental Care	Emergency Financial	Housing Services	Food Assistance	Outreach Programs	Mental Health Care
G R O U P	Males	●	●	●		●	●
	Females	●	●	●	●	●	
	Latinos/as	●	●	●		●	●
	Blacks	●	●	●	●		●
	Whites	●	●	●		●	●
	Non-White MSM	●	●	●	●		●
	White MSM	●	●	●		●	●
	IDU	●	●	●	●	●	
	Jail or Prison History	●	●	●	●	●	

**Table 6. Service Category Gap Ranking, 2002 compared to 2005**

Top Service Needs - “I need but do not receive this service”	Year	
	2002	2005
Dental	30%	41%
Nutritional Counseling	17%	???
Complementary Therapies	22%	???
Housing Services	19%	27%
Emergency Financial Assistance	17%	28%

Significant gaps remain in achieving the Healthy People 2010 goals for sexually transmitted infections in the TGA and in Connecticut. The NH/FF TGA witnessed 315 cases of sexually transmitted infections per 100,000 among all PLWH/A that are in care in the TGA. This rate is closer to the United States rate of 319.6 per 100,000 than the Connecticut average of 274.2 per 100,000 in the general population. The Healthy People 2010 goal of 3 per 100,000 is not realistically attainable, but efforts to diagnose and treat Chlamydia are active. Gonorrhea decreased to 95.1 cases per thousand among ‘In Care’ PLWH/A in the TGA compared to 82.2 in the general Connecticut populace. This compares to a national figure in 2004 of 113.5 per thousand. Again, significant gaps to the goal of 19 per 100,000 exist. Primary and secondary syphilis are only slightly elevated at 1.5 per 100,000 compared to the general population rate of 1.3 per 100,000 and the U.S. rate of 2.7 per 100,000. The goal of 0.2 per 100,000 set for 2010 is also distant.

### ***b. Greater Hartford Part A TGA Service Gaps***

The Greater Hartford TGA’s primary method for determining and monitoring service gaps is the needs assessment of persons with HIV/AIDS that is conducted every three years in conjunction with Part A-New Haven/Fairfield and Part B.

The result of the needs assessment indicated that for each service category listed in the survey, almost without exception, a greater percentage of persons reported needing services than in the previous joint needs assessment in 2002. At the same time, greater percentages reported using these services. During the three years between surveys, the number of persons living with HIV (not AIDS) and AIDS grew by an estimated

700 persons. During the same period, successful outreach efforts have engaged hundreds with medical care and Ryan White services. However, during this same three year period, resources at both the state and federal level appeared insufficient resulting in higher poverty rates and swelling waiting lists for supportive services.

Between 2002 and 2005 the percentage of persons regularly accessing medical care for HIV increased by nearly 20 percentage points--from 69.5 percent in 2002 to 86.6 percent in 2005. The percentage of persons using medication adherence support services tripled: from 13.8 percent to 39.2 percent. In excess of 10 percent more clients have case managers assisting them, 68.8 percent in 2005 as compared to 54.7 percent in 2002. In 2002, 24 percent of persons with HIV/AIDS who were surveyed indicated that they received the dental care they needed; in 2005, a full 60 percent are accessing oral health services. The absolute number of additional persons accessing services that these percentage increases represent is compounded by the increase in the number of persons living with HIV/AIDS between 2002 and 2005. The estimated number of persons aware that they were living with HIV or AIDS grew from 4671 to 5394 during this time.

The following table shows the other percentage increases in the number of persons using services available in the TGA.

**Table 7. Percentage increase in service use from 2002 to 2005**

Service	% Using Service in 2002	% Using Service in 2005
Paying for Medications	60.2	68.5
Mental Health Services	28.7	42.7
Substance Abuse Treatment	23.0	28.3
Emergency Financial Assistance	30.5	35.7
Food Programs	27.6	41.7
Transportation	30.7	36.0
Housing Assistance	21.1	25.2

While the needs assessment documented that there are more persons with HIV accessing services, the survey also indicated that there are increasing numbers of persons who need services. The percentage of persons needing but unable to get medical care increased from 4.3 percent in 2002 to 6.1 percent in 2005. The number of persons needing help paying for medications nearly doubled--from 5.1 percent in 2002 to 9.2 percent in 2005. The percentage of persons needing but unable to get substance abuse treatment, food, and transportation more than doubled; Mental health services and housing assistance nearly tripled. Table 8 shows that three times as many people need help paying for or finding housing in 2005 than in 2002.

**Table 8. Needed services but unable to get in 2002 compared to 2005**

Service	Need but Cannot Get in 2002 by Percentage	Need but Cannot Get in 2005 by Percentage
Medical Care for HIV	4.3	6.1
Case Management	7.9	14.0
Paying for Medications	5.1	9.2
Mental Health Services	6.9	19.1
Substance Abuse Treatment	4.7	9.9
Adherence Support	6.5	7.6
Emergency Financial Assistance	28.0	30.9
Food Programs	8.9	17.8
Transportation	7.9	17.2
Housing Assistance	10.6	34.4

Only for dental care, which had a 150 percent increase in the percentage of persons accessing oral health between 2002 and 2005, was there a corresponding decrease in the number of persons needing oral health services. In the 2002 needs assessment survey, Dental Care was the number one unmet need reported by

persons with HIV. Thirty-eight percent of persons surveyed said they were unable to get the dental care they needed. In 2005 the number of persons needing dental services is still too high at 30 percent.

The increase in the percentage of persons who need services such as Housing (34.4 percent), Emergency Financial Assistance (30.9 percent), Mental Health Services (19.1 percent), Food Programs (17.8 percent) illustrates the challenge facing the TGA. Persons with HIV who are now entering the system of care, as well as those who are not yet engaged, face multiple and enormous basic need barriers that must be addressed. As these persons are engaged with one service, they bring with them their need for help to address the other challenges that confront them. A system that is already overtaxed can only absorb and address these needs if resources are available to meet increased demand.

In FY 2006, the TGA received \$4,399,356 in Ryan White Title I formula and supplemental funding. In FY 2007, the TGA received \$2,917,583 in Part A formula and supplemental funding. The net reduction was \$1,481,773. The service gaps that the Planning Council has assessed and allocated Ryan White dollars to address occurred in a HIV service delivery environment that was built on 4.5 million dollars in Title I (Part A) funding. This service delivery system and HIV continuum of care have been hit by a loss of 1.5 million dollars. It will take some time for the Hartford TGA to assess the impact that the loss of Ryan White funding has on the availability of and access to services, and how this translates into service gaps and increased need for care and support.

The 2005 needs assessment also documented persisting disparities in service need based on race and ethnicity. For many services categories, whites report “needing but being unable to get” the service at lower rates than either blacks or Hispanics. Although the percentages are small (2.3 and 8.8 percent for blacks), blacks are four times more likely to be unable to get the medical care they need. Hispanics are nearly three times more likely to need medical care than whites, (6.1 percent compared to 2.3 percent.) The same is true for medications. Blacks are two-and-a-half, and Hispanics three-and-a-half, times more likely to be unable to get help paying for medications than whites. Blacks and Hispanics are twice as likely to be unable to get the adherence support they need. They are twice as likely to report having problems getting food, and three times as likely to need transportation. With regard to other support services, including case management, mental health counseling, substance abuse treatment, dental care, and housing assistance, there appears to be very little difference in the percent of each population accessing services and the percent of persons who are unable to get the services they need.

The Hartford TGA bases its assessment of persons who are out of care on data collected in surveys of persons who are not accessing medical care for HIV disease. In FY 2004 the Planning Council followed-up on the 2003 Unmet Need Framework with interviews with persons who are out-of-care in order to get demographic and service gap data. In 2006 the TGA conducted a second survey of persons who have not seen a medical provider for HIV for at least 12 months. Fifty-nine HIV positive persons who met the operational definition of not-in-care were interviewed in September and October 2006 by three outreach workers with experience in HIV care and prevention services and knowledge of the HIV/AIDS epidemic in the TGA. The vast majority of persons who are not-in-care in the TGA are black or Hispanic. Of the 59 persons interviewed, 46 percent (27) were black, and 46 percent (27) were Hispanic.

The persons who were interviewed indicated that they either were not interested in seeing a doctor for their HIV disease or did not want to see a doctor. Education, outreach and case management is needed to get people into care and keep them there.

### ***c. Care and Prevention Services Needs and Gaps Statewide***

The needs assessment and updated information from the new 2007 Epidemiological Report provided valuable information about client’s perception about the need and availability of HIV prevention services, as well as the care services they need. Statewide, the greatest reported service gap was for dental care (33%)

followed by housing related services (30%) and emergency financial assistance (29%). (See sidebar for rankings of the service needs.)

Approximately one fifth of respondents indicated need for mental health services, food assistance and outreach. 16% reported transportation needs. Primary care (6%), the most used service among respondents, was also the least needed service, although low need was reported for substance abuse counseling (8%), medication adherence (8%), assistance paying for medication (10%) and case management (11%).

Hartford respondents indicated less need for dental care, mental health services, assistance paying for medication, and food assistance. Need was greater by 1 or 2% for some non-core services including substance abuse counseling or treatment, emergency financial assistance, and transportation. Housing related services showed the greatest unmet need difference relative to the state (34% vs. 30%).

**Statewide Ranked Care Service Needs**

33% Dental Care  
30% Housing-related Services  
29% Emergency Financial assistance  
21% Outreach  
20% Mental Health Services  
20% Food Assistance  
16% Transportation  
11% Case Management  
10% Assistance in paying for Medication  
8% Substance Abuse Treatment \

8% Help with Medication adherence  
6% Primary Care

Among core services, New Haven/Fairfield TGA had the highest rate across the state of need for dental care, 41% vs. the state rate of 33%. Among non-core services, need is similar to the state rate except for housing related services where Hartford/Middlesex TGA showed the highest rate of need (34% vs. 30% state).

Non-Part A areas indicated similar rates of need in comparison to the state for most services; less need existed for dental care (24% vs. state 33%), and outreach (15% vs. state 21%). Other differences included lower reported need for medication adherence (5% vs. state 8%) and housing related services (27% vs. 30%).

Case management is a critical care and prevention component as indicated by the high use of case management in both the care and prevention settings.

Though individuals are receiving care, prevention for partners and risk reduction services are not being used to the fullest extent. 61% are not using prevention for partners services and 75% are not using risk reduction services. Clearly there is a need for HIV+ persons in care to receive regular prevention services to reduce increased infections.

PLWH/A are still in need of core and non-core services. These non-core services assist an individual to stay in care. Individuals who are in need of 2 or more services constitute 48% of the surveyed individuals. 23% of individuals indicated that they had 4 or more unmet needs. Furthermore, the picture of HIV prevention needs developed by the CPG through focus groups, key informant interviews and surveys revealed that individuals needed: Culturally appropriate HIV/AIDS information, safer sex workshops and prevention programs/outreach services and care services, including mental health, and substance abuse services, medication adherence programs, transportation, outreach. For youth prevention, effective strategies and messengers identified through CPG research and focus groups with youth include comprehensive health education in schools, respected speakers to convey true stories, real discussion, and parent education<sup>26</sup>:

**Statewide Critical Gaps**

**Gaps in Core Services**

- Mental Health (33%)
- Dental Care (20%)

**Supportive Service Gaps**

- Housing Related Services (30%)
- Emergency Financial Assistance (29%)
- Outreach (21%)
- Food (20%)
- Prevention Support Groups and services (12%)
- Note: There were few gaps for prevention services, although many indicated they did not need risk reduction or prevention for partners.

The numbers show that a high percentage (87%) of the

<sup>26</sup> The CPG in partnership with the CT DPH has formed the Connecticut HIV Prevention Youth Advisory Group to ensure that the voices of young people are heard in planning HIV prevention efforts in Connecticut. The advisory group will review research on effective HIV prevention strategies for youth, help plan and lead meetings with young people to get their feedback on HIV prevention and report its findings and feedback to the CPG.

respondents indicated that they had engaged in at least one of the risky behaviors, while one quarter had engaged in 4 or more of the risky behaviors listed, indicating a need for secondary prevention methods to be used by primary care providers. The following charts list the core services that are priorities across the state, and the priority populations. Included in this table are the identified barriers to receiving these services.

Priorities	Prevention Populations/Interventions
<ol style="list-style-type: none"> <li>1. Dental</li> <li>2. Case Management</li> <li>4. Emergency Financial Assistance</li> <li>5. Outreach</li> <li>6. Mental Health</li> </ol>	<ul style="list-style-type: none"> <li>▪ White MSM</li> <li>▪ Latino IDU</li> <li>▪ Black IDU</li> <li>▪ White IDU</li> <li>▪ Black Heterosexual</li> <li>▪ Latino/a heterosexual</li> <li>▪ Black MSM</li> <li>▪ Latino MSM</li> </ul>
<b>Barriers</b> Inability to pay Fear Lack of transportation Unaware of services and benefits	Note: Interventions are individual, group and community, peer and non-peer outreach, PCM, partner counseling and referral services

**The emerging needs are determined by predictors of service utilization and need.** In depth analysis of the SWNA data by DPH Epidemiologist Dr. Kenneth Carley revealed that certain demographic factors were predictors for service utilization and need.<sup>27</sup> This means, that these populations are more likely to be using or needing services, and the predictors can be used to forecast emerging needs and developing issues.

Predictors tell us what services a person is likely to need based on what group(s) he or she belongs to.

Predictors do not tell us every service need of every person.<sup>28</sup>

The following characteristics predict more need for core and non-core services by subgroups:

Emerging Needs	
Core Services	Supportive Services
<ul style="list-style-type: none"> <li>▪ Dental care for individuals from NH/FF EMA and/or who are fewer years as HIV+</li> <li>▪ Case management for individuals from Hartford EMA</li> <li>▪ Medical Adherence for the unemployed and Latinos</li> <li>▪ Substance abuse treatment for individuals who engage in unprotected sex</li> <li>▪ Mental health services for MSM</li> <li>▪ Primary care for younger individuals</li> <li>▪ Female and / or Younger, Latino, or Older</li> </ul>	<ul style="list-style-type: none"> <li>▪ Emergency financial assistance for the unemployed, IDUs and younger individuals</li> <li>▪ Food assistance for the unemployed, IDUs and individuals who are fewer years as HIV+</li> <li>▪ Outreach for males</li> <li>▪ Housing related services for individuals who have been in prison, engage in unprotected sex or are from Hartford EMA</li> <li>▪ Transportation for the unemployed, Latinos and individuals who have been in prison</li> </ul>
	<b>Prevention Interventions</b> <ul style="list-style-type: none"> <li>▪ Prevention for positives, MSM, being in prison, having had recent unprotected sex, IDU, being female, and/or younger, Latino or older</li> </ul>

<sup>27</sup> Predictors are variables used to predict or explain the value(s) of one or more dependent variables.

<sup>28</sup> *How are predictors used?* Predictors or factors that may predict substance use for a certain group of persons may be used to predict substance abuse among a similar group. Predictors can be used to predict other types of behaviors such as tobacco use, condom use, or medication adherence. It is simply taking a set of variables, information, or factors that can indicate a likelihood of some type of outcome. In this case, we are using predictors to help identify future emerging needs.

## D. INVENTORY OF COMMUNITY RESOURCES

### 1. COMMUNITY RESOURCES

Connecticut has a network of services that are catalogued and updated by Infoline, which was created in 1976 as a public/private partnership of United Way and the State of Connecticut. Infoline is a single source for information about community services, referrals to human services, and crisis intervention. It is an integrated system of help via the telephone. Accessed toll-free from anywhere in Connecticut by dialing 2-1-1, InfoLine operates 24 hours a day, 365 days a year. Multilingual caseworkers and TDD access are also available. Infoline has developed the state's most comprehensive database of human service resources and can be accessed online at [www.infoline.org](http://www.infoline.org).

In October 2006, an HIV/AIDS Prevention & Care Guide was launched on the United Way of Connecticut's 2-1-1 website. The Guide, a product of collaboration among 2-1-1, the CT DPH, the SWC, and the CPG, was created to provide comprehensive information about HIV/AIDS services in CT. The Guide, which is accessible both online ([www.infoline.org](http://www.infoline.org)) and by dialing 2-1-1, provides up-to-date HIV/AIDS care and prevention information, as well as information about other resources beyond the scope of HIV/AIDS. A detailed inventory (by county) of agencies that provide HIV/AIDS related service is located in the appendices.<sup>29</sup>

### 2. PLANNING AND FUNDING STRUCTURES

The following groups are planning and funding structures across the state and with whom planning efforts are coordinated.

#### Federal

*Centers for Disease Control and Prevention (CDC)*, one of the 13 major operating components of the Department of Health and Human Services (HHS), is the nation's premiere health promotion, prevention and preparedness agency. The CDC funds state and local health and education agencies and community-based organizations to conduct proven effective behavioral HIV prevention intervention programs for both HIV-positive and at risk populations. In April 2003 the CDC announced a new initiative, "Advancing HIV Prevention," which is a partnership with state health departments, HRSA, and other agencies, and which includes making HIV testing a routine part of medical care; creating new models for diagnosing HIV infections outside medical settings; preventing new infections by working with PLWH/A and their partners; and incorporating HIV testing into routine prenatal tests.

*HIV Prevention Community Planning Group*<sup>30</sup>, (CPG) a Federal (CDC) mandate for state jurisdictions to plan HIV prevention efforts in collaboration with the community EMA/TGA structure.

*Ryan White Part B Statewide Care Consortium*<sup>31</sup>, responsible for assessing and prioritizing statewide needs and making recommendations about the delivery of Part B health care and support services. Responsible for developing a statewide coordinated statement of need and a comprehensive care and prevention plan and/or updates to that plan.

<sup>29</sup> These numbers reflect the sites where services are provided. The number of services may be duplicated across programs and counties.

<sup>30</sup> The Connecticut HIV Prevention Community Planning Group (CPG) is comprised of community and DPH representatives with the purpose of setting HIV Prevention priorities for the State of Connecticut and developing a comprehensive HIV prevention plan for the State.

<sup>31</sup> Ryan White Part B provides funds for all states to improve the quality, availability, and organization of health care and support services for PLWH/A and their families. Part B Consortia are responsible for assessing and prioritizing regional needs and making recommendations about the availability and delivery of Part B services in each region.

Note: These two planning bodies will merge in October 2007 to form a comprehensive health care planning Body – the Connecticut HIV Planning Consortium.

*The Ryan White Program* administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) provides funding to develop, organize, coordinate, and operate more effective and cost-efficient systems for the delivery of essential health care and support services to people living with HIV/AIDS and their families. Connecticut provides services through the following:

- *Part A (formerly Title I)* provides funding through designated grantees to eligible metropolitan areas (EMA) and transitional grant areas (TGA) disproportionately affected by the HIV epidemic. In Connecticut these TGAs are New Haven/Fairfield Counties and the Greater Hartford area (including Hartford, Middlesex and Tolland Counties).
- *Part B (formerly Title II)* provides funding through the CT DPH to improve the quality, availability and organization of HIV/AIDS health care and support services. Included in this is the Connecticut AIDS Drug Assistance Program (CADAP), a pharmaceutical assistance program that pays for FDA approved HIV/AIDS antiretroviral and other drugs for persons living with HIV/AIDS.
- *Part C (formerly Title III)* directly funds public and private organizations for Early Intervention Services (EIS) grants to reach people newly diagnosed with HIV and ambulatory care. Services include HIV testing, case management and risk reduction counseling. Part C also funds Capacity Development and Planning Grants to support organizations in planning and service delivery and in building capacity to provide services. In CT, ambulatory medical clinics (e.g. Community Health Centers) are the recipients of these grant awards.
- *Part D (formerly Title IV)* funds public and private organizations directly to provide family-centered comprehensive care and community-based services to children, youth, women and their families living with HIV/AIDS. Children, Youth & Family AIDS Network (CYFAN), a program of CT Primary Care Association, receives Part D funding to provide family support/case management services to HIV infected/exposed and affected children and their families in the cities of Stamford, Bridgeport, New Haven and Hartford. CYFAN also provides coordination of maternal-child health care and facilitates early entry into care for HIV positive women.
- *Part F includes:*

CT AIDS Education and Training Centers Program (CAETC) that provides training, consultation, and information to providers and consumers. The CAETC hosts numerous statewide HIV Forums on issues relating to health care, medications and prevention.

Dental Reimbursement and Dental Partnership Programs provide reimbursement to dental schools, postdoctoral dental education programs, and dental hygiene programs for oral health care of individuals living with HIV.

Minority AIDS Initiative (MAI), created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities, provides funding across several Department of Health and Human Services (DHHS) agencies and programs, including the Ryan white Program. The Ryan White component of the MAI was codified in the recent Modernization Act. In CT, both TGAs and Part B are the recipients of MAI funding.

Special Projects of National Significance (SPNS) funds research and development activities for assessing the effectiveness of care models, providing support for innovative models of HIV/AIDS service delivery, and for assisting the replication of effective models. In CT, Community Health Center, Inc. (CHC), a federally qualified health center, is the recipient of a SPNS grant for its “Norwalk Smiles” program, which will provide comprehensive dental care to more than 700 HIV positive people at three sites in Norwalk.

- *HOPWA or Housing Opportunities for Persons with AIDS* funding is provided through the Department of Housing and Urban Development (HUD) and addresses the specific housing need and social service needs of low income persons diagnosed with HIV/AIDS and their families.

### **Other Collaborating Connecticut State Agencies and Programs**

*State of Connecticut Department Social Services (DSS)* provides supportive services to people living with HIV, including the CADAP. It offers a broad range of services for the elderly, persons with disabilities, families and individuals. It is also the state agency responsible for administering the Rehabilitation Act, the Food Stamp Act, the Older Americans Act and the Social Security Act. DSS administers housing assistance, emergency assistance, childcare assistance, Temporary Assistance for Needy Families (TANF), State Administered General Assistance (SAGA), employment and training services, and Medicaid coverage, among others.

- *HUSKY Insurance Program* is the Connecticut health insurance that provides coverage for low-income eligible children and teenagers up to age 19 and their families/caregivers.

*State of Connecticut Department of Mental Health and Addiction Services (DMHAS)* is the State agency that promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment, which includes special populations such as individuals living with HIV/AIDS.

*State of Connecticut Department of Children and Families (DCF)* is the State agency that provides (for this population) a wide variety of services for children and their families including child protection, behavioral health, juvenile justice and prevention services. For this population DCF may provide substance *abuse*, mental health, and other medical services.

*State of Connecticut Department of Correction (DOC)* provides safe, secure, and humane supervision of offenders with opportunities that support successful community reintegration. DOC provides testing and care and support services for inmates with HIV/AIDS.

*State of Connecticut Department of Education (SDE)* provides educational programs, leadership and curriculum development, planning, evaluation, assessment and data analyses to residents and organizations in CT.

## **E. PROFILE OF PROVIDER CAPACITY AND CAPABILITY**

In FY2006 - 07, the Ryan White Part B services provided care to 2,125 unduplicated clients through the Connecticut AIDS Drug Assistance Program (CADAP). More than 2,000 additional clients were served through the Statewide Care Consortia providers (e.g. case management, emergency financial assistance, housing, transportation, mental health, oral health) and the Minority AIDS Initiative (MAI). In December 2006, the Health Care and Support Services (HCSS) of the CT DPH issued a competitive Request for Proposals (RFP) for all Ryan White Part B funded services. An RFP for state-funded services for Medication Adherence Programs was also issued in 2006. The contracts awarded under the Part B RFP commenced on July 1, 2007 and will be for one year funding cycle, with renewal for two additional years. The Part A and B service categories are divided into core medical and support services. Core Medical services must be funded at least at 75%. Ryan white Part A and B service allocations are indicated in the following table.

Table 9.

FFY Ryan White Parts A & B 2007 Service Allocations	Part B	Part A NH	Part A H	
	totals	totals	totals	Totals
<b>10. Core Medical Services Sub-total</b> <small>Footnote 5</small>	<b>\$2,372,144</b>	<b>\$3,344,267</b>	<b>\$2,053,095</b>	<b>\$7,769,506</b>
a. Outpatient / Ambulatory Health Services	\$154,685	\$916,071	\$623,527	<b>\$1,694,283</b>
b. AIDS Drug Assistance Program (ADAP) Treatments				
c. AIDS Pharmaceutical Assistance (local)			\$60,333	<b>\$60,333</b>
d. Oral Health Care	\$91,139	\$30,805	\$145,482	<b>\$267,426</b>
e. Early Intervention Services			\$71,918	<b>\$71,918</b>
f. Health Insurance Premium & Cost Sharing Assistance			\$19,547	<b>\$19,547</b>
g. Home Health Care			\$14,381	<b>\$14,381</b>
h. Home and Community-based Health Services				
i. Hospice Services				
j. Mental Health Services	\$63,592	\$490,611	\$120,001	<b>\$674,204</b>
k. Medical Nutrition Therapy	\$8,100			<b>\$8,100</b>
l. Medical Case Management (+ Treatment Adherence)	\$2,052,828	\$1,274,338	\$683,445	<b>\$4,010,611</b>
m. Substance Abuse Services—outpatient	\$1,800	\$632,442	\$314,461	<b>\$948,703</b>
<b>11. Support Services Sub-total</b>	<b>\$406,654</b>	<b>\$707,706</b>	<b>\$652,987</b>	<b>\$1,767,347</b>
a. Case Management (non-Medical)				
b. Child Care Services				
c. Emergency Financial Assistance	\$227,249	\$127,316	\$16,489	<b>\$371,054</b>
d. Food Bank/Home-Delivered Meals	\$24,764	\$153,170		<b>\$177,934</b>
e. Health Education/Risk Reduction				
f. Housing Services	\$54,815	\$315,863	\$317,802	<b>\$688,480</b>
g. Legal Services			\$32,810	<b>\$32,810</b>
h. Linguistics Services	\$7,862			<b>\$7,862</b>
i. Medical Transportation Services	\$38,403	\$111,357	\$154,505	<b>\$304,265</b>
j. Outreach Services				
k. Psychosocial Support Services	\$53,561		\$131,381	<b>\$184,942</b>
l. Referral for Health Care/Supportive Services				
m. Rehabilitation Services				
n. Respite Care				
o. Substance Abuse Services - residential				
p. Treatment Adherence Counseling				
<b>12. Total Service Dollars</b>	<b>\$2,778,798</b>	<b>\$4,051,973</b>	<b>\$2,706,082</b>	<b>\$9,536,853</b>

## Infrastructure Development

Provider staff development and capacity are an integral part of yearly needs assessment and plan development activities. To better assess the capacity of Connecticut providers, the state has moved to a uniform reporting system to collect AIDS and chronic disease data. This section highlights the limitations of the current data collection Uniform Reporting System (URS) and the future benefits of the upgraded URS or the new AIRS/URS software.

### *URS and statewide AIDA databases*

To better serve the HIV/AIDS at risk population of CT the DPH, AIDS and Chronic Diseases Division Section in 2003, contracted with Defran Systems Inc., a New York software developer, to develop a software

product called the Uniform Reporting System (URS) specific to the needs of Connecticut. The United States Department of Health and Human Services, HRSA, CDC, and New York State supported the development of the software. The URS has the capacity to collect, and report HIV/AIDS prevention and Ryan White Parts A and B data on a statewide basis. We have largely achieved the previous plan's goals which included reduced duplication of effort, improved accuracy of reporting, and access to an efficient, low cost data collection and maintenance tool for service providers. This software is a versatile HIV prevention, education and care-specific data automation system. This HIV prevention and care-specific data automation system is a relational database that will link other systems of particular relevance to HIV prevention, such as the activities in Prevention Education, Comprehensive Risk and Counseling Services (CRCS), and HIV Health Care/Social Services.

The software was distributed to publicly funded HIV counseling and testing sites, Ryan White sites, drug treatment sites, and other contracted agencies in early 2003. The software was also installed on selected personal computers at DPH. De-identified data is extracted at the various sites and sent back to DPH by encrypted email attachment where it is consolidated into a single database (AIDA). This database is installed on an older DPH server that users can access from the DPH.

The URS allows DPH to clearly document programmatic efforts and successes in HIV prevention and care. Advantages and characteristics of the system include:

- Improved efficiency: Captures client information, tracks encounters and services, generates reports, and produces billing claims, performs all required functions, minimizes inaccuracies and confidential data communication between contractor services sites and the AIDS and Chronic Diseases Section, essential to meeting programmatic goals
- Fulfills federal reporting requirements by generating custom reports for CDC and HRSA and State reporting requirements are met by monitoring the use of services, contract compliance, and quality assurance for unduplicated clients within and across services. Generates custom reports for the DPH, the region, local agencies, OPM, and the legislature
- The URS software can run on a desktop computer, laptop, or on any network platform

#### *Current Challenges*

Contractors continue to have difficulty designating their limited staff resources to do the URS data entry. The Ryan White Parts A&B providers are now required to submit service data via the URS extracts instead of the previous quarterly paper reporting to adhere to the current DPH requirements. The Prevention providers continue to submit paper reports as well as URS extracts. Another problem for contractors continues to be that subcontractors must travel to their contractors' site and transport confidential client information for entry into the system. DPH has supplied an employee confidentiality agreement to them for this purpose, but the process still remains logistically difficult. Implementing a Wide Area Network just for URS is expensive, yet it is the only way to connect contractors and subcontractors sited at different locations.

The URS software is currently installed with approximately 70 contractors. Periodic emails are sent to contractor URS system administrators to notify them of any changes such as software version upgrades that are available to download from a secure website. All URS program changes and version upgrades are tracked by Defran Systems, Incorporated.

The statewide data base, AIDA has proved to be an important resource to monitor provider activities. It does however have a limited capacity to generate all the reports that are required to adequately monitor provider activities. This is especially true for the Prevention services. The URS/AIDA system was never designed to comply with the newer data reporting requirements of the CDC. We are currently improving our capacity to generate ad hoc reports. The existing AIDA server is, however, somewhat slow and shows signs of reaching its capacity to handle the amount of data that has been collected.

The URS is also based on FoxPro, a software that is no longer supported by MicroSoft. The State of New York has redesigned the URS to meet both the new CDC and HRSA reporting requirements and implemented it in Visual FoxPro which is supported by MicroSoft

Future activities include:

- Modification of the AIRS to conform to Connecticut reporting requirements.
- Migration of all the providers from the URS to the Visual FoxPro-based AIRS
- Installation of AIDA and loading of data into a newly purchased, increased capacity server at the DPH
- Offering continued training classes, such as System Administration program setup and updates, Prevention Services data entry and Care Services data entry including specialized trainings on Counseling and Testing based on new CDC testing guidelines January 2007, federal reporting requirements and subsequent software updates
- Giving providers more feedback on reporting requirements via detailed reports of their data submissions during quarterly site visits, including key care indicators.
- Improving the quality of medical care including vital health-related supportive services
- Ensuring that available demographic, clinical and health care utilization information is used to monitor the spectrum of HIV related illnesses and trends in the local epidemic

### **Quality Management Program**

The goal of the State's Part B Quality Management Program (QMP) is to sustain or improve the overall health and quality of life for persons living with HIV/AIDS (PLWH/A). The process for achieving this goal encompasses a multifaceted, integrated team approach that continues to operate within a continuous quality improvement model through various interrelated activities. These activities are reviewed and evaluated on an ongoing basis to improve program outcomes. Services are delivered to Part B eligible people living with HIV/AIDS (PLWH/A) and their families in accordance with: 1) the Ryan White Part B regulations; 2) the most current Public Health Service (PHS) Guidelines for PLWH/A; 3) standards developed by the Connecticut Department of Public Health AIDS & Chronic Diseases Section (ACDS), Health Care & Support Services Unit (HCSS); and, 4) other nationally accepted standards of care (e.g., National Association of Social Work Standards of Practice and Care).

One of the quality management objectives realized in 2007 was evaluating the extent that clients' HIV Viral Load and CD4 test results were entered into the URS database. By querying the database for the dates of the tests a baseline can be established to measure the number of Part B clients "in care."

In addition, case managers are required to adhere to the standards of care in order to ensure that clients who are assessed as needing a health or related service are appropriately referred. The status of these referrals is monitored by reviewing a sample of client records that have a documented need for referral. The importance of this referral scrutiny is to ensure that clients are linked to necessary health and related services to improve health outcomes. Increased emphasis on tracking referrals will be included in 2008 DPH sponsored Case Management trainings

All Part B funded contractors receive four (4) site visits per year, one per quarter and additional visits if requested or required. During every site visit, program and financial data are comprehensively reviewed. Files are randomly selected and audited for provision of emergency financial assistance, transportation services, etc. If discrepancies are identified, HCSS Health Program Associates will provide technical assistance and review findings with the QMP and HCSS supervisory staff. Contractors may be requested to submit a corrective action plan if the same discrepancy is found through subsequent monthly telephone contacts.

To ensure the quality of HIV prevention programs, a staff member from the HIV Prevention Unit is assigned to each contractor to provide administrative oversight of their contract. In addition, a staff member is

designated to serve as an Intervention Specialist for each funded intervention. The Intervention Specialist is responsible for observing interventions and or conducting process monitoring to ensure that they are being implemented with fidelity. Reports are written based on monitoring that includes observations and recommendations.

All contractors are required to submit quarterly program reports as well as monthly reports and extracts through the Uniform Reporting System (URS). Prevention Unit staff conduct quarterly site visits, one of which is in conjunction with HCSS staff, in order to monitor the progress of funded programs. Monitoring tools have been developed for each funded Effective Behavioral Intervention (EBI), Counseling, Testing and Referral (CTR), Comprehensive Risk Counseling Services (CRCS) and Drug Treatment Advocate (DTA) program to be used during visits to ensure the quality of programs provided by contractors.

In the 2007 Interim Progress Report to CDC, the HIV Prevention Unit identified three specific actions for 2008 to strengthen the capacity of grantees/contractors to deliver interventions that are appropriate, understandable, and acceptable for the target population served. DPH staff will ensure that all contractor staff conducting interventions from the Diffusion of Effective Behavioral Interventions (DEBI) Project will receive training either locally or out of state.

The Prevention Unit will continue to offer the HIV prevention counselor and the HIV/AIDS educator certificate trainings for contractor staff. The trainings will ensure that HIV counselors and educators are familiar with CDC and state guidelines and protocol for conducting HIV prevention counseling and HIV prevention education and are prepared to provide these services in the community. DPH will monitor the progress by keeping track of those trained and determining that all new HIV prevention counselors and HIV/AIDS educators who are funded to conduct these interventions will have demonstrated the required skills to receive a certificate of training in the respective program.

HIV Prevention staff will also continue to provide technical assistance to all contractors on the interventions they are conducting and will request capacity building assistance through CDC's Capacity Request Information System (CRIS) as requested and as is appropriate. DPH staff will document problems that contractors are having in implementing interventions and will document the request for capacity building made through the CRIS system. The outcome will be that our contractors will be more equipped to effectively implement and adapt their interventions to the target populations with whom they are working.

### *Improving Capacity through Training*

DPH's training coordinator through the HCSS and Prevention Unit assures the highest standards of training by supporting and promoting the development of linkages with academia, and the professional development of direct care & prevention, administrative, and managerial staff. A variety of training workshops, and conferences are planned and coordinated by the training coordinator designed to meet the educational needs of funded HIV care and prevention providers.

In 2006, the Integration & Care Training Coordinator conducted a training needs assessment with HIV care and prevention providers across the state. Ninety-nine (99) surveys were completed. Of the 99 surveys, 2% were primary care providers, 32.3% were case managers, 35.4% were prevention counselors, and the remaining 30% were mental health, substance abuse, education, and administrative providers. The data from the needs assessment revealed that providers felt the following topics were very important: Secondary Prevention (58.9%); Case Management Training (57.6%); HIV & Mental Health (54.3%); Substance Abuse (49.4%); Prevention Outreach (51.7%); and Medication Adherence (52.3%). The survey also found that more training was needed in the following areas: Updates on: Sexually Transmitted Diseases, HIV & Hepatitis, Harm Reduction Strategies, and Cultural Competency. The results from the training needs assessment helped guide the development of the Integration & Care & Prevention (ICP) Statewide Training Catalog. The catalog is designed to provide HIV care and prevention providers with general information on Statewide Trainings regarding HIV related topics. The catalog also provides information on Continuing Education (CE) workshops geared towards those providers who are currently certified as HIV counselors and educators

throughout the state. The CE workshops are also open to non-certified providers; such as care providers who are required by Part A to attend HIV related trainings (Part A Standards of Care). The following is the ICP Training Mission, Goals & Objectives for Fall 2007-Spring 2008 Training Plan:

**Mission:** To provide a statewide education and training forum across local, regional and statewide programs involved in HIV/AIDS services delivery.

**Goal:** To provide HIV related capacity building training and technical assistance to all funded HIV Care & Prevention Providers across the State of Connecticut.

### Objectives

1. To ensure that all newly hired HIV Care and Prevention providers attend & complete Pre-requisite Course within one year of hire
2. To ensure that all existing HIV Care and Prevention providers attend & complete required courses per HRSA/CDC funded standards of care/contractual agreements
3. To provide funded HIV Care and Prevention Providers with basic pre-requisite training a minimum of twice per year - This training includes: HIV 101, STD's, Basics of HEP (A, B, and C), Sexual Assault, Domestic Violence, Substance Abuse 101, Cultural Competency, and Medical and Legal Basics
4. To provide all newly funded HIV Prevention Counselors with training on the Fundamentals of HIV Prevention Counseling within one year of hire
5. To provide all newly funded HIV Care Case Managers with training on the Fundamentals of HIV Case Management within one year of hire
6. To provide yearly continuing education (CE) workshops between September –May. (Part B/CDC funded providers are required to take a minimum of 12 hours of trainings per year in order to maintain certification)
7. To assist in the cross training of staff across the state for Integrating Routine Prevention Counseling into Medical Care

Note: A copy of the ICP Statewide Training Catalog and survey results is included in the appendices.

## F. ASSESSMENT OF SERVICE GAPS

The SCSN recommendations and data were assessed by the Data Work Group during the update and revision to the SCSN 2007. In 2003, three major issue areas were identified by the Ad Hoc committee and confirmed by the Consortium as having impact on overall service delivery and coordination of HIV/AIDS services and funding mechanisms that include Ryan White and non-Ryan White programs. These issue areas have not changed. In fact, to address the critical statewide gaps and emerging needs, and to respond to the directive to create and submit a Comprehensive Plan that describes the organization and delivery of Part B funded HIV care and support services and integration of prevention within the plan, the Ad Hoc committee considered the SCSN recommendations and developed overall statewide / infrastructure gaps. They are **collaborative planning, integration of services, and service delivery**. The Data Work Group revised the recommendations for the SCSN based on new data, additional studies, and a changing funding environment and proposed initial implementation strategies for this plan update.

### Process for Determining Unmet Need for Primary Medical Care for HIV- Statewide Unmet Need Estimate – Update

*Deviation from HRSA/HAB Unmet Need Framework and Technical Assistance Methodology* Part B grantees are required to develop epidemiological measures for establishing the number of out-of-care HIV+ individuals.<sup>32</sup>

<sup>32</sup> Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, Public Law 106-345, re-authorized amendments of 2000 contains multiple provisions focused on enhancing access to primary care for persons living with HIV disease who are not in care. These new provisions also include enhancements to your needs assessment requirements.

The Ryan White Amendments of 2000 require Part A and B grantees to provide a specific estimate of the number of individuals who are HIV seropositive and who are not receiving regular HIV related primary medical care. The process is referred to as “estimating unmet need for primary care”. In prior years, the DPH epidemiologists with assistance from a Work Group developed a predictive model from which the DPH estimated unmet need for primary medical care. Connecticut’s method of estimation does align with the standardized estimation model used in over 40 states throughout the nation.<sup>33</sup> The required unmet need estimate is used in at least three (3) competitive Federal grant applications. The HRSA has requested Connecticut to re-calculate the estimate of unmet need for primary care.

HRSA has provided technical assistance to the DPH for this express purpose. HRSA Consultants explained that using a standardized approach will allow for comparisons between Connecticut’s unmet need and unmet need in other states. The Department of Public Health hosted on June 9, 2006 a meeting with Mosaica and Ryan White Part A and B grantees. The meeting produced a federally acceptable, revised approach to draw upon the best available data in Connecticut. However, there were significant limitations to the proposed process. Mosaica had an expectation that linking and de-duplicating clients in various databases<sup>34</sup> would be the appropriate method to arrive at an estimate of unmet need. A letter was sent from Commissioner J. Robert Galvin of the Department of Public Health to Commissioner Patricia Wilson-Coker of the Department of Social Services (DSS) requesting specific data sets<sup>35</sup> to assist with estimating unmet need. DSS provided aggregate numbers and stated that they were “unable to determine the breakdown between HIV and AIDS.” Many of the data sets recommended by Mosaica were not available, could not be de-duplicated and /or were not reliable. It is anticipated that future estimates will be based on full viral load reporting through an electronic reporting system implemented by the State.

The CDC no longer provides the numbers of PLWH/A to states and EMAs for use in their Ryan White applications and on which to base their estimates of unmet need. The DPH HIV/AIDS Surveillance Unit was directed by the CDC to use the CDC-provided “SAS Programs for Creating Integrated Epidemiologic Profiles” to calculate the adjusted prevalence for PLWH/A in Connecticut. After receiving the latest version of the programs from the CDC, the HIV/AIDS surveillance unit found that they contained errors which would not allow the calculation of an adjusted prevalence for 2005. The HIV/AIDS surveillance unit was advised by its CDC project officer that the CDC was aware of these problems and that a corrected set of programs would be distributed in 2007. The unadjusted prevalence estimates generated by the CDC-provided “SAS Programs for Creating Integrated Epidemiologic Profiles” were used in the determination of unmet needs. These represent the best prevalence estimates currently available to DPH but may vary from the prevalence estimates generated by the state’s two Ryan White Part A TGAs.

*Unmet Need Estimate.* Table 8-1 shows the current model for estimated unmet need for primary care services in the state of Connecticut. The total percent of HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need) is twenty-eight percent (28%).

<sup>33</sup> After attending the 2003 HRSA All Titles Conference - that was focused specifically on determining unmet need – the Department of Public Health coordinated a working committee to estimate unmet need in the state of Connecticut. Representatives from the Hartford and New Haven/Fairfield Title I Offices and Title II grantees worked with the DPH Epidemiologists to develop a sound methodology to estimate unmet need. HRSA felt that this method, though methodologically sound, was not consistent with the data sets used in other states and hence recommended that Connecticut receive technical assistance from Mosaica. Connecticut does not fit the federal standardized estimation process because of data limitations. For example, Connecticut’s process to collect HIV surveillance information differs from other states. Specifically, Connecticut does not collect CD4 and viral load information which serve as the basis for the methodology used by HRSA to estimate unmet need for primary care.

<sup>34</sup> Medicaid Fee for Service, HUSKY, SAGA, CADAP, VA Hospital data, Hospital Discharge data, URS, DOC, PLWH, PLWA,

<sup>35</sup> Databases on the number of unduplicated clients with HIV and AIDS served by the Department of Social Services in Medicaid, ADAP and other DSS programs that pay for healthcare who had received at least on prescription for Antiretroviral therapy (ART) and/or CD4 count and/or has a viral load count for the 2005 calendar year, or if that is not possible the most recent 12 month continuous period.

<b>Table 10 – 1 Population Sizes</b>	<b>Number</b>	<b>Data Source(s)</b>
Number of persons living with AIDS (PLWA), as of 12/31/2005	6,989	HARS (HIV related surveillance reports)
Number of persons living with HIV (PLWH)non-AIDS aware as of 12/31/2005	2,278	HARS
Total number of HIV+/aware as of 12/31/2005	9,267	
<b>Care Patterns</b>	<b>Number</b>	<b>Data Source(s)</b>
Number of PLWA who received the specified HIV primary medical care during the 12-month period (01/01/2005 - 12/31/2005)	5,057	HARS and data from the Unmet Needs tables from the two Part B TGAs in Connecticut
Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period (01/01/2005 - 12/31/2005)	1,622	HARS and data from the Unmet Needs tables from the two Part B TGAs in Connecticut
Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (01/01/2005 - 12/31/2005)	6,679	
<b>Results</b>	<b>Number</b>	
Number of PLWA who did not receive the specified HIV primary medical care	1,932 (28%)	
Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	656 (29%)	
Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	2,588 (28%)	

Source: Connecticut Department of Public Health, 2006

### Future efforts and emergent issues

In October 2006, the DPH in collaboration with the SWC, the CPG and United Way's Infoline 2-1-1, launched the HIV/AIDS Prevention & Care Guide. The Guide, accessible both online ([www.infoline.org](http://www.infoline.org)) and by dialing 2-1-1, provides up-to-date HIV/AIDS care and prevention information, as well as information about services and resources beyond the scope of HIV/AIDS. Maintaining the accuracy and update of this information is tasked to 2-1-1 staff. Promotional materials and flyers have been created and marketed to statewide agencies to ensure people in need of services are aware of the information. A future effort will be to conduct additional promotion and marketing of this service on a statewide basis not only to community-based organizations, but to private practitioners and social service agencies.

Identifying individuals who may be HIV+ for testing is always a concern and focus of the DPH. The DPH has discussed the importance of continuing to look for new approaches to identifying this population with all contracted HIV Counseling and Testing sites in order to develop strategies and approaches. One of the methods being considered is the social networks strategy. In its bid for HIV prevention services to begin in July 2008, DPH will give priority to programs that propose models for counseling and testing that have a strong outreach component or that use strategies such as social networking in order to identify and test new HIV infected individuals. Future efforts include implementation of the social network strategy in the Counseling and Testing system, training of peer educators, and follow up and referral of HIV+ identified individuals into care services.

To fully implement CDC's 2006 Testing Guidelines for adults, adolescents and pregnant women in health care settings, current CT legislation will need to be amended. Currently, the CT Privacy and Confidentiality law requires that separate informed consent be obtained from the patient prior to testing for HIV.<sup>36</sup> Some level of pre-test counseling is also required. The DPH has begun work with the Government Relations Office to assist with new proposed legislation that would address the barriers to fully implementing the guidelines.

The CDC's 2003 HIV initiative includes increasing prevention services for HIV positive individuals, increasing the availability of HIV testing and incorporating HIV prevention into routine medical care. There is a need for increased training for medical providers on incorporating HIV prevention into routine care regardless of the patient's HIV status. During 2008 DPH will collaborate with the New England AIDS

<sup>36</sup> "HIV-related test[s]" may not be conducted without either: 1) written consent or; 2) oral consent which has been documented in a medical record. Connecticut General Statutes Annotated (CGSA) §19a-582. The term "HIV-related test" includes a test for any agent "thought to cause or indicate the presence of HIV infection." CGSA §19a-581 (6). Thus, HIV-specific consent is required for an antibody test, a viral load test, or any other test, regardless of its purpose, which indicates the presence of HIV.

Education and Training Center at Yale University and the STD/HIV Prevention Training Center in Massachusetts to begin training physicians and other health care providers on offering routine HIV testing in their clinical practices.

The DPH has been collaborating with Part A-D agencies to implement a Medical Case Management model to align with HRSA's definition and that is consistent across all Parts. Technical assistance has been provided to the DPH and its partners by a HRSA consultant. Future efforts include the development of a consistent statewide definition for medical case management, standards of care that reflect this model, and provision of training for both new and current Ryan White funded medical case managers in medical case management standards. Monitoring the outcomes of Medical Case Management will also provide data to assess the effectiveness of this model on the health status and medical outcomes of People Living with HIV/AIDS.

Rural and non urban areas continue to present unique problems in relation to health care and supportive services for individuals living with HIV/AIDS. In 2006, a subgroup of the State Wide Consortium's Data Work Group was tasked with identifying key issues that impact service delivery in rural areas. Their findings include the following: a) some dentists are unwilling to work with populations covered by Medicaid and/or living with HIV; b) transportation is a major concern – no public services exist, and in many small towns there is no taxi service; c) lack of health or dental clinics in rural areas requiring clients to go to other distant services for HIV testing and services; d) persons with SAGA and Medicaid have difficulty getting primary care, and e) insufficient case manager or overloaded case managers. Although the rate of new AIDS cases reported in CT is far lower in the rural areas, the continuing and future challenge of providing services to lower income persons with AIDS continues to be great in these locales. Recommendations have been made to communicate the need for transportation services for PLWH/A to the Department of Transportation. The challenge remains to find a local coordinated public transport provider capable of providing affordable, and transportation services that will address the needs. Additional resources are also needed to establish rural health and dental clinics and provide funding to hire additional medical case managers.

Reductions in Ryan White funding to Connecticut's Parts A and B have had an impact on the services provided to people affected and infected with HIV/AIDS. With the reauthorization mandate that at least 75% of funding be allocated to core medical services, the 25% remaining balance for support services is proving to be insufficient in getting people into and keeping them in primary medical care. It is an established fact that lack of or inadequate transportation, housing and food are barriers to individuals in accessing care. As a result of funding reductions, transportation services have been limited and/or eliminated or clients assigned to a certain number of transports per month, thus causing them to make choices about which appointments to keep. Food pantries/meals have been limited or completely eliminated, and resources for housing services have been reduced. It is reported that clients have "dropped out of or disengaged from care" for fear of more losses in services; others have relapsed and new clients are on wait lists because of the reduction in agency staffing. Clearly, despite additional state funds allocated to attempt to cover the Ryan White funding gaps, service gaps still remain in the supportive arena. Emerging issues resulting from loss of services include: clients disengaging from services, client relapse, increase in substance abuse and mental health issues, eviction from housing, increase in homelessness, clients becoming sicker and presenting more often to emergency departments and/or increased hospitalization; disengagement from medication adherence; increase in opportunistic infections, as well as reverting to high risk behaviors. Processes and outreach protocols need to be created and implemented to capture this population that is newly 'falling out of care.

## SECTION II:

### WHERE DO WE NEED TO GO, AND HOW WILL WE GET THERE?

*“There are a lot of good programs but somehow they are not connected. There is still a tremendous need for services for people living with HIV/AIDS especially Latinos and undocumented citizens.” - A consumer who attended the Latino Outreach Seminars.*

#### A. PROCESS TO DESIGN THE IDEAL CONTINUUM OF CARE

##### 1. INITIAL COLLABORATIVE PLANNING: ASSESSING OUR PROGRESS

The Connecticut Department of Public Health (DPH) is in its 3<sup>rd</sup> year of a comprehensive planning process to ensure that resources are efficiently used to deliver necessary medical and support services in an ideal care system.<sup>37</sup>

The SWC convened by the DPH, continues its primary mission to conduct statewide planning and to facilitate information sharing across local, regional and statewide programs involved in HIV/AIDS service delivery. This multi-year 2004 to 2007 statewide Comprehensive Plan for the delivery of HIV/AIDS care services informs the policy and Part B funding decisions implemented by DPH and has a defining feature that aligns with HRSA and CDC expectations to integrate care and prevention while establishing an improved infrastructure for ascertaining priorities for the allocation of funds. By the year 2007, Connecticut will offer the highest level of integrated planning, funding and policy-making that supports a robust continuum of prevention and care services responsive to the needs of persons living with HIV/AIDS.

This update to the plan outlines the progress thus far by the Consortium to analyze data to identify the priority gaps in the statewide continuum of care, to develop a process to create and implement a new plan, to assess the feasibility of and design for integrating care and prevention, and ultimately to design the best strategies that best address the gaps, establish an improved infrastructure for fund allocation and result in a fully unified care and prevention plan.

The efforts outlined in this update are a product of collaborative planning meetings and efforts by various representatives of Ryan White Parts, CPG, community and provider agencies, consumers and public participants from across the state with the same dedication to ensuring that a comprehensive continuum of care and prevention exists for residents of Connecticut. Three statewide gaps were identified in the early planning stages by the Ad Hoc committee and confirmed by the Consortium that impact overall service delivery and coordination of the delivery of HIV/AIDS services and funding mechanisms that include Ryan White and non Ryan White programs. Statewide gaps fall into three major categories, collaborative planning, the system, and services and programs. Each represents the means to achieve a comprehensive plan that includes both care and prevention with overall outcomes of reduced HIV infections and connecting people living with HIV/AIDS to the appropriate care and support services they need. Identified within each step are activities related to the three major strategies Public Awareness, Collaboration, and Infrastructure development.

The Plan outlined specific objectives and activities that have all been accomplished within each major strategy. In the first year of the plan, the Consortium identified three work groups to carry out the activities outlined in the Plan: The Ad Hoc Committee for the Integration of Care and Prevention, The Data Work Group and the Public Awareness Committee. When reviewing the objectives, the new committees realigned the assigned activities to fit under each work group as depicted in the following tables. The tables show our

<sup>37</sup> Under the Ryan White CARE Act, the Comprehensive HIV Service Plan provides a common understanding of our current HIV/AIDS epidemic, and a framework to move Connecticut's system of care toward an ideal continuum of care.

progress and accomplishments during the 2004-2007 time period in addressing the three major gap categories of collaborative planning, the system, and services and programs. The three strategies were public awareness, collaboration and infrastructure development.

### Data Work Group Activity Schedule

Objective: Linking efforts through Collaboration		2005
<b>a. Unified care and prevention efforts</b>		✓
▪ Continue to integrate efforts (CPG & SW Consortium) to create one unified plan; have joint appointments; and partner in joint projects.		✓
<b>b. Data collection processes and linkages</b>		✓
▪ Assist planning bodies to gain consumer buy-in		✓
▪ Gain consensus from SW Consortium		✓
▪ Make survey questions compatible w/ URS		✓
– Review URS format (data unit at DPH to compare URS & standard questions)		
▪ Re work established protocol for gathering data (CPG/RWPB Panel on Assessment & Evaluation)		✓
– Standardize the type of data collected		✓
– Create set of core / standard questions		✓
▪ SW Needs Assessment: Use same/similar questions as Title I surveys for the six HRSA priority services for states		✓
<b>c. Complementary and supportive information (for the SCSN)</b>		✓
▪ Work with CPG to assess emerging needs		✓
▪ Use state BRFSS <sup>38</sup> efforts		✓
▪ Use data from University studies		✓
▪ Use other available HIV specific studies		✓

The Data Work Group has coordinated the ***first Connecticut Statewide HIV/AIDS Care and Prevention Survey***. The concept was first conceived in the fall of 2003 in a meeting of the Statewide HIV/AIDS Care Consortium's Data Work Group<sup>39</sup>. A meeting with representatives from the RW Title I PC's and TII was coordinated outside of the Data Work Group to discuss unifying efforts between the two Title I N/A efforts and focused on the different data needs of Title I and Title II planning bodies. Discussion included the HRSA identified 6 core service categories, the different timelines of assessments for planning bodies, the inclusion of secondary prevention questions, the feasibility of conducting a combined survey, the development and agreement over an instrument, and aligning questions with the State's Uniform Reporting System (URS) data fields.

**2005 Statewide In Care Needs Assessment Survey**

- 8 counties participated
- 1,135 completed the survey
- 64 provider agencies participated

The participants agreed that a collaborative effort through a statewide needs assessment would be in the best interest of each planning body and consumers throughout Connecticut. More importantly, it would maximize limited resources and help to relieve the burden of numerous surveys on consumers. More importantly, it was essential to get a picture which was truly representative of the population being served. (See sidebar to the right.)

**Representative of PLWH/A in CT**

- 35% White
- 35% Black
- 28% Latino
- 60% male
- 39% female
- 23% 20-39 yrs
- 49% 40-49 yrs
- 28% 50 + yrs

It was agreed that all planning bodies conduct studies on a three year cycle,

<sup>38</sup> Behavioral Risk Factor Surveillance System, CDC's telephone survey that tracks health risks in the United States.

<sup>39</sup> Ryan White Part A Planning Councils Hartford and New Haven/Fairfield EMAs, Part B State Department of Public Health AIDS and Chronic Diseases Division, Statewide HIV/AIDS Care Consortium members (representative of the Department of Corrections, Department of Children and Families, Department of Social Services, Department of Mental Health, Connecticut AIDS Drug Assistance Program (CADAP), Connecticut Department of Public Health Sexually Transmitted Disease (STD) Program, and the Connecticut Department of Mental Health and Addiction Services (DMHAS). UConn Health Center, State Department of Education, among others) Part C, Part D, Consumers from around the state, and members of the Community Planning Group for Prevention.

and they would (1) contribute to the statewide needs assessment, both monetarily by earmarking money in their budgets for stipends and by offering members for survey development and analysis of data, and (2) conduct supplementary studies in “off years” of the three year cycle (i.e. focus groups, population/subject specific studies) and include this data in their individual applications for funding. For survey implementation and analysis the state was divided into three major areas: two Title I EMAs (urban) and the rest of the state (rural).

The Data Work Group has achieved all of its current objectives. In year 2006-2007 they hope to be working on a statewide out of care survey and client satisfaction.

#### Public Awareness Work Group Activity Schedule

Objective: Public Awareness & Training		2006
a. Use statewide Consortium to develop and disseminate messages focusing on the Integration of prevention and care	<ul style="list-style-type: none"> <li>Created protocol</li> <li>Developed and disseminated quarterly newsletters called HIV/AIDS News and Notes</li> </ul>	
b. Begin to disseminate information	<ul style="list-style-type: none"> <li>In the process of creating a website that will serve all HIV/AIDS planning bodies statewide</li> <li>Designed an HIV/AIDS care and prevention newsletter with CPG</li> </ul>	
c. Collaborate with other State Departments	<ul style="list-style-type: none"> <li>Discussed sending information through CADAP and disseminating newsletters through other Governmental partners (e.g. DMHAS, DSS, DOC)</li> </ul>	
d. Education outreach to special populations, e.g., hard of hearing and non-English speaking	<ul style="list-style-type: none"> <li>Developing a resource list for a listserv</li> <li>Beginning planning for community-wide trainings for consumers and providers on information related to HIV Planning</li> </ul>	

The Public Awareness Work Group has successfully designed, created and disseminated four editions of the HIV News and Notes Newsletter. The group has achieved its current objectives.

#### Integration of Care and Prevention Committee Activity Schedule

Objective: Infrastructure Development and Enhancement – Implementing the ACTION PLAN	2006
a. Strengthen infrastructure across state agencies/departments	✓
<ul style="list-style-type: none"> <li>Create a narrative and graphic of the ideal collaborative statewide effort – outlining the mandates of HRSA, CDC, benefits and difficulties of collaboration</li> </ul>	✓
<ul style="list-style-type: none"> <li>New: Explore combined SW Consortium &amp; CPG meetings</li> </ul>	✓
b. Review structure of regional consortia	✓
c. Enhance competitive funding process to require collaboration across providers ensuring comprehensive treatment.	✓
d. Involve care providers in primary prevention and prevention workers in secondary prevention (referred back to Ad Hoc from Data work group)	✓
e. Review funding process to encourage linkages	✓
f. Planning processes include consideration of de duplication of funding	✓
g. With Part A require Ryan White funded programs to have links to agencies funded for prevention	✓
h. Redesign a contract monitoring process that involves URS	✓
i. Collaborate with Part A to create standardized QA formats and intake forms	✓
j. Efficacy planning /funding through strategic integration of prevention, counseling and testing, and care services	✓
k. Assess role of Statewide Consortium as part of statewide plan	✓
l. Create and implement standards of care for all service categories including prevention	✓
m. Cross training of care and prevention outreach and case management workers	✓

The Integration for Care and Prevention (ICP) Committee, formerly the Ad Hoc Committee, oversees the work of the Statewide Consortium's Work Groups, and is responsible for the third strategy: Infrastructure Development and Enhancement. As with the other two strategies, activities were realigned to fit within the purview of the Committee. For example, cross training efforts were moved from the public awareness work group to the ICP committee. During the first year and a half, the ICP committee provided guidance to the Public Awareness work group in the development of their goals and objectives, initiated Cross training of care and prevention workers and curriculum development through DPH, recommended change in regional consortia structure, developed a graphic of the ideal collaborative statewide effort created for streamlining planning efforts and completed objectives A, B, C and D required activities for 2004-05 as depicted in the table above.

The implementation of the plan has occurred over the past three years with significant progress in collaborative efforts across planning bodies, providers and state agencies across the state. This involved a reassessment of the current service regions, change in infrastructure, combined training and education practices, merging of planning body activities and collaborative needs assessment efforts.

Recognizing the importance of linking care with prevention, the SWC and its committees have embarked upon this planning process to integrate systems and completed their first two year objectives. The next major step will be to begin the integration of the plan components for Care and Prevention. Beginning April 2006, the Statewide Consortium and the CPG held joint meetings on a quarterly basis, and committees began meeting together beginning June 2007. These two significant planning bodies began laying the framework for their unified Comprehensive Plan to be submitted in 2009. The combining of the two bodies will be complete on October 24, 2007 when the 39 members will meet together for the first time.

Collaborative Planning involves assessing unmet need; aligning statewide planning processes to respond to service delivery issues; keeping the system flexible to respond to changing needs; keeping clients in care, developing a systematic approach to maximize funding resources is not always employed; reviewing funding options and assessing duplication of effort; and coordinating planning across all HIV related funded care and prevention systems to maximize funding and resources. Public Advisory Planning processes include the collaborative meetings and activities of the CPG, the SWC, and CADAP Advisory Group, the Quality Assurance planning and the Uniform Reporting System committee.

## 2. REASSESSING CURRENT PRACTICES

### The Statewide HIV/AIDS Care Consortium

The DPH addresses disparities in HIV care, access, and services through an HIV care continuum that involves Part B programs as well as state funded programs and initiatives. In addition the DPH also funds and oversees a statewide Consortium that includes a diverse membership of up to 40 individuals (providers, consumers and agencies) who are appointed by the Co-Chairs. From 2005-2007 the Statewide Consortium reassessed and revised its role to a) advise the State Department of Public Health and each TGA on the provision of effective planning and the promotion, development, coordination, and administration of HIV/AIDS health care and support services; b) develop an integrated care and prevention comprehensive plan, and c) establish a collaborative process to identify unmet need and out of care individuals. The Consortium will

#### Members of the Statewide HIV/AIDS Consortium

- The Greater Hartford and New Haven/Fairfield County Part A TGA Planning Councils
- Regional Ryan White Part B Contractors
- Part C Community Health Centers
- Part D Contractor (CYFAN)
- SPNS Dental Contractor
- Statewide Organizations: CT HIV Prevention Community Planning Group (CPG), CT AIDS Resource Coalition (CARC), UCONN Correctional Managed Health Care, Project TLC (AIDS Project Hartford)
- Government agencies: DMHAS, DOC, DSS: CADAP, and the Co-Chair seat held by DPH
- Consumer membership is reflective of the HIV/AIDS epidemiological profile of the epidemic

hold its final meeting on October 10, 2007 to approve updates for the 2008 Comprehensive Care and Prevention Plan. It will merge with CT's HIV Prevention Community Planning Group (CPG) on October 24, 2007 to form the new statewide comprehensive health care planning organization – the Connecticut HIV Planning Consortium (CHPC).

## **RFP Process**

In 2003, the DPH began to re-evaluate the way in which they allocate funding to ensure the existence of a coordinated system of care through enhanced linkages with prevention efforts that address gaps in Connecticut's service delivery system, and improve the lives of people living with HIV/AIDS.

- An RFP process has been in place that requires applicants to respond to HRSA identified service categories for care funding. A separate RFP process has been in place that requires applicants to respond to CDC identified initiatives and effective behavioral interventions for prevention funding.
- Over the past 13 years, HIV public health planning bodies have conducted planning and priority setting based on consumer demand. Applicants are required to base proposals on the plans and priorities set forth in the Comprehensive state plans.
- Applicant proposals and priorities for care funding are measured against the SCSN. Agencies are required to establish measurable outcomes. Funding is allocated according to criteria established through evidence-based processes.
- Applicant proposals and priorities for prevention funding are reviewed and rated on the merit of the proposal and whether or not the agency demonstrates the need for the proposed service and the expertise to deliver the service.
- The DPH conducts a fair bidding process that is open and competitive. The process is also consistent with the state RFP as mandated by CT Public Health Codes.

In November 2006, the DPH issued an RFP for an estimated \$3,600,000 to fund Ryan White Part B approved services. Because Ryan White had not yet been reauthorized at the time the RFP was issued, the document referenced former Part B core and non-core services in seeking health and supportive service contractors. However, applicants were instructed, that the Modernization Act legislation, when passed and signed into law, could change the way in which Ryan White funding would be allocated to states and cities across the country; therefore, no specific amounts of funds would be earmarked to fund core or non-core services prior to application review. Potential applicants were also advised that funding would be for a three (3) year period beginning July 1, 2007, subject to the availability of funds and satisfactory performance in provision of services. The deadline for submission of proposals was February 7, 2007. Other pertinent information relevant to this RFP:

- The DPH conducted a fair bidding process consistent with the state RFP as mandated by CT Public Health Codes
- Applicant proposals and priorities were measured against the Statewide Coordinated Statement of Need. Agencies were required to establish measurable outcomes (DPH provided sample outcomes as guidance for each service category).
- Questions regarding the preparation of proposals in response to the RFP had to be submitted in writing by 4:30 p.m. on January 10, 2007. All questions were collected, compiled and answered in one document, which was posted on the DPH website and also e-mailed to applicants who provided e-mail addresses to the Project Manager.
- RFP Bid announcements were placed in major statewide newspapers
- Two review panels of four members each were assembled. Reviewers were representative of care and prevention, legal advocacy, clinical and consulting organizations. Reviewers were provided with an orientation concerning the RFP process and the absolute need to maintain confidentiality concerning applicants and proposals.
- Score sheets were also developed for the reviewers' use, as well as a rating scale with point ranges (maximum of 115 possible points) from excellent to poor (106-115 Excellent; 97-105 Good, 85-104 Satisfactory, 75-84 Poor, and below 75 Unsatisfactory). Proposal, which scored a "poor" or

“unsatisfactory,” were automatically eliminated from funding consideration. Those scoring “Excellent” were recommended for priority funding.

- During the actual review process, panels were divided into North and South sections and met on different days to discuss and rate proposals and prioritize proposals based on final scoring criteria.
- A total of 25 proposals valued at \$6,613,561 were submitted for review of which 19 were funded, based on final scores, through Part B. Because of a reduction in federal funding to Connecticut for Part B (Base and ADAP), funding for the selected contractors was based on an available \$3,480,804.

### **The Connecticut HIV Planning Consortium (CHPC)**

To design an ideal continuum of care, the DPH, the SWC, and the CPG convened several meetings through the Integration of Care and Prevention Committee to assess the feasibility of integrating care and prevention, analyze data to identify the priority gaps in the continuum of care, design the best strategies to undertake to address the gaps and to develop a process to create and implement the new plan.

This document represents the culmination of the 2004-2007 plan to establish a process to integrate care and prevention, and a transition year in during which the combined planning group, the Connecticut HIV Planning Consortium will create its first fully integrated HIV Care and Prevention Plan for the State of Connecticut. It is understood that this plan will be a transitional document, and that it will set the framework for the new care and prevention plan.

### **This year of transition**

Integrated planning is the first step that begins to align HRSA and CDC expectations to integrate care and prevention. DPH, Parts A, B, C, D, and CPG have begun to assess current links and overlap, and initiated discussion on a process whereby a plan that would involve both care and prevention could be developed. Currently, the CPG prevention plan for FY 2005-2008 has been updated. The next plan will be a multi-year plan for FY 2009 as required by CDC. Areas in which care and prevention are already linked are identified within the plan. The updates to both plans describe the multi-level process of change in system methodology, behavior and practice change so crucial to the combining of these two statewide bodies. Recently, a CDC project officer attended a Community Planning Group meeting at which the integration efforts were discussed, and in practice (combined committee meetings). The CDC has recently recognized the State of Connecticut as a national model of a thoughtfully and effectively executed merging of the HRSA funded HIV Care Planning Consortium and the CDC funded Community Planning Group for HIV Prevention.

The 2004 – 2007 Comprehensive Plan established a timeline of 5 years to have a fully integrated plan. In the process of integrating care and prevention activities and increased collaboration, the planning bodies determined that a combined statewide planning body would be the most efficient and cost effective way to conduct public health planning for HIV/AIDS in the state of Connecticut. This combining of the planning bodies has thus far been a successful planning effort and will be fully combined by October 2007. December 2007 will be its first meeting as a combined planning body, the Connecticut HIV Planning Consortium. This effort is being highlighted at the HIV Prevention Leadership Summit in May, 2007.

- The Reauthorization of Ryan White resulted in the Modernization Act of 2006 released in December. The Modernization Act has made significant changes by setting minimum funding requirements for core services, (Part A-C 75%), creating new structures for funding and changing the formula for distributing funds through Parts A and B.
- By the end of 2008, Connecticut will offer the highest level of integrated planning, funding and policy-making that supports a continuum of prevention and care services responsive to the needs of persons living with HIV/AIDS through a combined Care and Prevention Plan.

## Reaching Our Goal: The Unified Care and Prevention Plan

During 2007 the Statewide Consortium in collaboration with the CPG has assessed and revised their current comprehensive plans, completed any remaining objectives, and began to align activities and service provision/funding with the new care and prevention plan. The table below depicts the objectives for 2007-2009 that will result in the submission of the fully unified plan.

2007	2008	2009
<ul style="list-style-type: none"> <li>▪ Work with CPG to incorporate fully unified plan into their process</li> <li>▪ Continue to reassess and incorporate changes as needed</li> <li>▪ Address recommendations from SCSN to include in combined plan</li> </ul>	<ul style="list-style-type: none"> <li>▪ Conduct Statewide Consortium and CPG review (concurrence) and public hearing process</li> <li>▪ Planning for new statewide Needs Assessment</li> <li>▪ Submit fully unified plan (CDC)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Submit fully unified plan (HRSA)</li> <li>▪ Continue to refine the operations of the new CT HIV Planning Consortium</li> </ul>

## B. SHARED VISION

### CHPC Vision/Mission

A shared vision has emerged as a result of the move to link and integrate care and prevention services. Organizations, systems, and providers throughout the state are recognizing the importance of collaboration to creatively respond to the needs of the target population. The shared vision and expressed mission of the new CT HIV Planning Consortium (CHPC) is to create a coordinated statewide care and prevention system in which the rate of new HIV infections is reduced, and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services.

## C. STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

The SCSN is updated every three years. Data to update the SCSN in FY 2006 includes evaluative studies, the needs assessment, and supplemental information. The following are highlights of the SCSN. [For detail, please see the full report in the Appendix.]

**Disproportionately Affected:** AIDS has disproportionately affected specific demographic groups and groups who are underserved or that face particular barriers making it more difficult to access the HIV/AIDS care they are:

- Latinos, MSM, males and younger individuals encounter service gaps at disproportionate rates.
- The unemployed, individuals engaging in unprotected sex, have been in prison, are IDU or are fewer years HIV+ are also disproportionately reporting gaps in services.

**Cross-cutting themes** representing commonalities identified across Ryan White Parts, among assessments of need, AIDS surveillance data, SCSN development discussions, and for the first time survey information and need analyses of the prevention efforts through the CPG include:

- Health Care Costs (impacting coverage and co-pays PLWHIV/AIDS)
- Improved Health Status / Return-to-Work
- Cultural Competency / Linguistic Complexity / Serving the Deaf and Hard of Hearing
- Non-medication Adherent Individuals
- People Not in Care
- Prevention Needs of People Living with HIV/AIDS

**Critical gaps** in service delivery were identified across Ryan White bodies as the most consistent, pressing services to be addressed, both for individuals that are already in and not yet in care. The gaps are separated into two categories, services that address physical needs and services that address medical needs.

1. *Core Service Needs*

- Mental Health (33%)
- Dental Care (20%)

2. *Supportive Service Needs*

- Housing Related Services (30%)
- Emergency Financial Assistance (29%)
- Outreach (21%)
- Food (20%)
- Prevention support groups and services (12%)

**Emerging needs** are based on data trends (e.g., people with HIV are living longer) and our knowledge of the external environment. Specific areas identified are:

*Core Services*

- Dental care for individuals from NH/FF EMA and/or who are fewer years as HIV+
- Case management for individuals from Hartford EMA
- Medical Adherence for the unemployed and Latinos
- Substance abuse treatment for individuals who engage in unprotected sex
- Mental health services for MSM
- Primary care for younger individuals

*Supportive Services*

- Emergency financial assistance for the unemployed, IDUs and younger individuals
- Food assistance for the unemployed, IDUs and individuals who are fewer years as HIV+
- Outreach for males
- Housing related services for individuals who have been in prison, engage in unprotected sex or are from Hartford EMA
- Transportation for the unemployed, Latinos and individuals who have been in prison

*Prevention Interventions*

- Prevention for positives, MSM, being in prison, having had recent unprotected sex, IDU, being Female and / or Younger, Latino, or Older

The following recommendations represent broad goals based on SCSN findings and SCSN development discussions. The goals directly respond to the data collected and reflect thematic service delivery needs that were identified through studies of disproportionately represented and underserved populations, cross-cutting themes, critical gaps, and emerging needs.

Recommendations are not prioritized and should be referenced by Ryan White programs to demonstrate consistency with the SCSN in annual grant applications to HRSA.

**SCSN Recommendations**

The following recommendations were developed to inform the allocation and use of resources for service delivery in the State of Connecticut for PLWH/A and to guide the implementation activities of the Comprehensive Plan. The Data Work Group created a set of implementation activities that are detailed in Section III.

***Service Utilization***

**Recommendation a.** Engage PLWH/A (out-of-care and in-care) into primary care by fully integrating comprehensive risk counseling services (CRCS) with medical case management through, for example,

coordinated services, co-location, cross training, outreach, referral. Note: Attention should be given to specific issues arising in areas such as rural areas that may not have significant representative data.

**Recommendation b.** HIV Care providers should offer or refer prevention interventions including a combination of individual interventions group level interventions, peer and non- peer outreach, prevention case management, partner counseling and referral services, community level interventions and structural interventions<sup>40</sup>.

### ***Service Needs***

**Recommendation a.** Continue focusing on the six core HRSA services as prioritized. In anticipation of the 2008 needs assessment, gather further information on the additional core services resulting from the 2006 Ryan White Modernization Act and additional information on rural and non-urban areas, and obtain data /resource information by partnering with DOC, DSS, DMHAS, and SDE.

**Recommendation b.** Fund supportive services to ensure that people have access to and remain in primary care. For example, services such as transportation, housing related services, EFA, and food

**Recommendation c.** Provide training and education for primary care providers and clinicians on secondary prevention methods.

**Recommendation d.** Communicate the need for transportation services for PLWH/A to the State of Connecticut Department of Transportation, and work with them to provide services through a Locally-Coordinated Public Transit Human Services Transportation Plan, particularly in rural areas where transportation services do not exist.

### ***Emerging Needs***

**Recommendation a.** To identify emerging needs, in order to better anticipate the at-risk populations and identify ongoing trends in the HIV+ population, and to reinforce the need for supportive services, use methods such as: Statistical modeling processes, ADA Database, Local input, Out of Care survey, Provider survey, and other data sources, e.g., literature search, organization reports, among others.

### **Implementation**

How will these recommendations be implemented?

- The recommendations will be implemented to the fullest extent possible through activities identified by the Data Work Group and as appropriate through the DPH and its contractors. Limitations that will apply include the “end of contract period” and allowances for changes that may occur as a result of the Ryan White Treatment Modernization Act. The activities will be included in the updated version of the Comprehensive Plan that will be submitted to HRSA by December 30, 2007.
- In October, the SWC and the CPG will merge their planning bodies, and develop a planning process for a combined Comprehensive Plan. The early implementation strategies will be included in the new plan, as will other strategies that will be developed during the planning process.

## **D. COORDINATION WITH OTHER SERVICES**

### **1. FULL INTEGRATION OF CARE AND PREVENTION PLANNING PROCESSES**

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<sup>40</sup> Structural interventions refer to public health interventions that promote health by altering the structural context within which health is produced. Most prevention interventions focus on individuals, encouraging them to make healthy choices. Structural interventions focus “outside” of the individual, trying to expand the healthy choices available to individuals, create norms that make healthy choices acceptable, and ensure that individuals have the power and resources to access healthy choices. Structural interventions require an understanding of the factors in the social, political, physical, and economic environment, the risk environment, that create poor health; structural interventions address or challenge these factors. This means that sometimes, structural interventions for HIV prevention focus on areas that do not seem to relate to HIV. For example, increasing the availability and accessibility of drug treatment can contribute to HIV prevention goals, as can such things as increasing options for after-school leisure, reducing homelessness, and challenging race, class, and gender inequalities. Leif Mitchell Assistant Director, Community Research Core, Center for Interdisciplinary Research on AIDS (CIRA) Yale University School of Medicine, [http://cira.med.yale.edu/about\\_us/bios.asp?PID=4#publications](http://cira.med.yale.edu/about_us/bios.asp?PID=4#publications)

The Connecticut HIV Planning Consortium has fully linked Prevention (Community Planning Group) with Care activities.

Current areas of collaboration between care and prevention include:

- Needs Assessment
- Quality Assurance
- Information/data sharing
- Resource Inventory
- Out of care surveys
- Focus groups
- Key Informant Interviews
- Combined meetings ( will be fully integrated on October 24, 2007)
- Membership
- Gap analysis
- Monitoring the epidemic – collaboratively developing data collection methods that include both care and prevention
- Prioritization
- Cross training/education and capacity building

## 2. LINKAGES WITH OTHER FUNDING STREAMS

*Better links between care and care providers:* Parts A, B, C and D indicated a need to establish better links between care and care providers. What is intended here is not only the sharing of information across funding streams but the exploration of better ways to make referrals, and serve clients across the state. This may involve a reassessment of the current service regions. During 2007, the DPH convened collaborative meetings and received technical assistance from HRSA on the new medical case management definition. During the process, the DPH has assisted in creating a statewide picture of case management services for HIV and is working with Parts A, C and D to develop general statewide case management standards.

*Fund Monitoring:* The CHPC will also be continuing collaborative efforts to explore ways to monitor funding across titles by region to assess funding levels. This would assist in answering the questions: Are we over funding or are we under funding? A first effort has been made with the statewide case management picture of funding and service provision.

## E. SHARED VALUES

Shared values are essential to the development of an ideal continuum of care and serve as the fundamental standards upon which a collaborative plan evolves. But, what is that ideal continuum when looking at an entire state, which includes various funding streams and both care and prevention services? The following definition was determined by the committee and approved by the Consortium and CPG. The statewide plan for an ideal continuum of care is a totally integrated care and prevention system that is:

- Comprehensive
- Culturally and developmentally appropriate
- Easily accessible and coordinated through multiple points of entry
- High quality and evidence based
- Cost effective
- Actively engaged in providing current and accurate information, services and support, appropriate referral mechanisms, skill building techniques for both clients and providers, decision making involving standards of care, and a coordinated system to assess individuals at various points of entry

## SECTION III: THE COMPREHENSIVE PLAN INTEGRATION OF CARE WITH PREVENTION

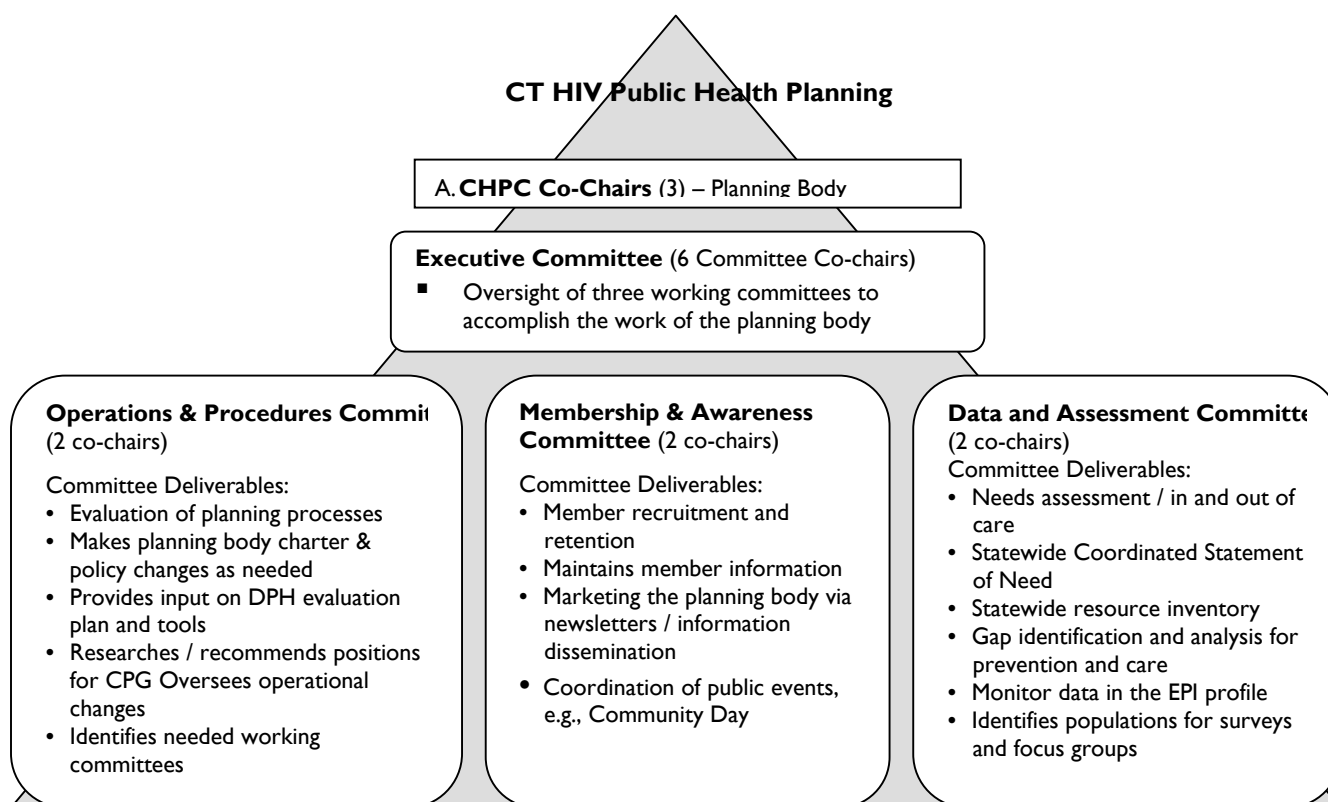
### A. PROCESS TO DESIGN STRATEGIES (IMPLEMENTATION ACTIVITIES)

Strategic planning has been an integral part of the integration of care and prevention process. The Connecticut Care and Prevention Plan for 2004-2007 was the first step toward integrating both care and prevention data and planning into one comprehensive document. The 2004-2007 Plan objectives and strategies being accomplished, the Integration of Care and Prevention Committee, originally the Ad Hoc Committee of the Statewide Consortium, proposed combined meetings of the planning bodies. In October 2006 it became evident following a combined CPG/SWC statewide meeting, that the desire was now to not only combine plans, but planning bodies as well to ensure a comprehensive continuum of care and prevention services for PLWH/A in Connecticut. From that point and moving forward, the process strategies have focused on how best to integrate the two planning bodies in a manner that would ensure continuity of prevention and care planning goals and responsibilities, while creating a smooth transition to a new planning body comprised of both care and prevention providers and people living with HIV/AIDS. The following pages outline the transition year goals; structure of the new planning body, objectives to achieve the stated goals, and to fulfill federal requirements.

### B. GOALS, OBJECTIVES AND STRATEGIES - OVERARCHING GOALS FOR 2007-2008

- To effectively combine the statewide care and prevention planning bodies into one CT HIV Planning Consortium
- To plan and write a fully integrated care and prevention plan
- To provide education sessions across the state to consumer groups and providers

To achieve these goals, the Integration of Care and Prevention committee conceived a structure that would encompass the responsibilities of both planning bodies and fulfill federal requirements.



The entire Planning Body will be responsible for the creation and maintenance of one HIV Public Health Plan. This plan will optimize resources for public health services and meet federal requirements. The process involves 1) assessing the needs of Connecticut's people living with and /or affected by HIV/AIDS and reviewing the most effective and evidence based intervention methods; through 2) planning collaboratively among the service and consumer communities to create a Comprehensive Plan every 3 years w/ annual updates to CDC and HRSA that will meet identified needs, 3) making funding priority recommendations for care and prevention services, and 4) continuing efforts to coordinate services and provide training opportunities; and finally 5) evaluating the quality of programs and services to assure cost effectiveness and efficacy of meeting identified needs.

To achieve the overarching goals and continue to meet state and federal requirements, the following A) objectives and B) recommended strategies were designed to create and work within a unified system of care and prevention, and structured to accomplish the major task of completing the unified plan for submission in 2009. The implementation strategies were developed by the Data Work Group and reviewed by the SWC and presented at two statewide public hearings. They will be implemented through the newly formed CHPC during this year.

<b>A. OBJECTIVES TO ACHIEVE THE GOALS AND FULFILL STATE AND FEDERAL REQUIREMENT</b>	
<b>Structure</b>	
	<ul style="list-style-type: none"> <li>▪ Confirm operating structure, bylaws, membership roles and responsibilities, recruitment and retention processes of new planning body</li> <li>▪ Confirm process to meet all federal requirements for the Human Resources Services Administration and the Centers for Disease Control and Prevention</li> </ul>
<b>Unified Plan &amp; Needs Assessment</b>	
	<ul style="list-style-type: none"> <li>▪ Develop and write one unified and integrated care and prevention plan</li> <li>▪ Conduct second statewide needs assessment and develop a Statewide Coordinated Statement of Need (SCSN)</li> <li>▪ Coordinate focus groups, one-on-one and key informant interviews and surveys to identify care and prevention needs, barriers, and service gaps</li> <li>▪ Coordinate with the Youth Advisory Group (YAG) for needs, gaps, and prevention and care efforts targeting youth at risk Conduct public forums and focus groups to assess the impact of Ryan White funding cuts in the TGA areas and statewide</li> <li>▪ Continue to consider emerging needs, the needs of those who are out of care or have unmet needs</li> <li>▪ Continue to monitor the CADAP formulary through the Statewide CADAP Advisory Group, add HIV and other medications as recommended by the group, and maintain the "no-wait list" status</li> <li>▪ Continue to review prevention outcomes relevant to funded Effective Behavioral Interventions (EBI) being implemented through statewide HIV prevention and care agencies</li> </ul>
<b>Continued coordination and collaboration</b>	
	<ul style="list-style-type: none"> <li>▪ Across Parts C, D and F to assure that services are not duplicated and that individuals and families affected and infected by HIV/AIDS receive quality care and prevention services in a culturally appropriate and accessible environment</li> <li>▪ Across all Ryan White Parts to develop standards of care, performance measures and assessment tool reflecting the medical case management model</li> </ul>
<b>Training / Information</b>	
	<ul style="list-style-type: none"> <li>▪ Continue to promote the on-going cross training of prevention and care staff, as well as supervisors and program managers through a system of continuing education workshops and seminars</li> <li>▪ Begin initial planning to implement informational sessions across the state to inform care, prevention and other relevant social service organizations on the integration of care &amp; prevention and promote the work of the CHPC</li> <li>▪ Develop / present an integration of care &amp; prevention workshop at the 2008 HIV Prevention Leadership Summit</li> </ul>

**B. RECOMMENDED STRATEGIES / ACTIVITIES TO ADDRESS CARE AND PREVENTION GAPS (TO BE CARRIED FORWARD INTO THE UNIFIED PLAN OF 2009)**

The following recommended strategies represent broad goals based on SCSN findings and SCSN development discussions. The goals directly respond to the data collected and reflect thematic service delivery needs that were identified through studies of disproportionately represented and underserved populations, cross-cutting themes, critical gaps, and emerging needs. Note that the recommended strategies are not prioritized and should be referenced by Ryan White programs to demonstrate consistency with the SCSN in annual grant applications to HRSA. Recognizing that this is a year of transition and that the CHPC will be fully engaged in integration activities and tasks to fulfill federal requirements, these strategies will be carried forward into the combined plan of 2009.

The recommended strategies were developed to inform the allocation and use of resources for service delivery in the State of Connecticut for PLWH/A. They are organized into three categories: Service use, service needs, and emerging needs. Consideration was given to how these recommendations would be interpreted within the context of care and prevention.

**Service Use:**

- Engage PLWH/A (out-of-care and in-care) into primary care by fully integrating comprehensive risk counseling services (CRCS) with medical case management through, for example, coordinated services, co-location, cross training, outreach, and referral. Note: Attention should be given to specific issues arising in areas such as rural that may not have significant representative data.
- HIV Care providers should offer or refer prevention interventions including a combination of individual interventions, group level interventions, peer and non- peer outreach, prevention case management, partner counseling and referral services, community level interventions and structural interventions<sup>41</sup>.

It is acknowledged that case management is a critical care and prevention component as indicated by the high use of case management in both the care and prevention settings in the SCSN report. Though individuals are receiving care, prevention for partners and risk reduction services are not being used to the fullest extent. 61% are not using prevention for partners services and 75% are not using risk reduction services. Clearly there is a need for HIV+ persons in care to receive regular prevention services to reduce increased infections.

**Service Needs:**

- Continue focusing on the six core HRSA services as prioritized. In anticipation of the 2008 needs assessment, gather further information on the additional core services resulting from the 2006 Ryan White Modernization Act and additional information on rural and non-urban areas, and obtain data /resource information by partnering with DOC, DSS, DMHAS, and SDE.
- Fund supportive services to ensure that people have access to and remain in primary care. For example, services such as transportation, housing related services, EFA, and food.

<sup>41</sup> Structural interventions refer to public health interventions that promote health by altering the structural context within which health is produced. Most prevention interventions focus on individuals, encouraging them to make healthy choices. Structural interventions focus “outside” of the individual, trying to expand the healthy choices available to individuals, create norms that make healthy choices acceptable, and ensure that individuals have the power and resources to access healthy choices. Structural interventions require an understanding of the factors in the social, political, physical, and economic environment, the risk environment, that create poor health; structural interventions address or challenge these factors. This means that sometimes, structural interventions for HIV prevention focus on areas that do not seem to relate to HIV. For example, increasing the availability and accessibility of drug treatment can contribute to HIV prevention goals, as can such things as increasing options for after-school leisure, reducing homelessness, and challenging race, class, and gender inequalities. Leif Mitchell Assistant Director, Community Research Core, Center for Interdisciplinary Research on AIDS (CIRA) Yale University School of Medicine, [http://cira.med.yale.edu/about\\_us/bios.asp?PID=4#publications](http://cira.med.yale.edu/about_us/bios.asp?PID=4#publications)

- Provide training and education for primary care providers and clinicians on secondary prevention methods.
- Communicate the need for transportation services for PLWH/A to the State of Connecticut Department of Transportation, and work with them to provide services through a Locally-Coordinated Public Transit Human Services Transportation Plan, particularly in rural areas where transportation services do not exist

PLWH/A are still in need of core and non-core services. These non-core services assist an individual to stay in care. Individuals who are in need of 2 or more services constitute 48% of the surveyed individuals. 23% of individuals indicated that they had 4 or more unmet needs. Furthermore, the picture of HIV prevention needs developed by the CPG through focus groups, key informant interviews and surveys revealed that individuals needed: Culturally appropriate HIV/AIDS information, safer sex workshops and prevention programs/outreach services and care services, including mental health, and substance abuse services, medication adherence programs, transportation, outreach. The SCSN numbers show that a high percentage (87%) of the respondents indicated that they had engaged in at least one of the risky behaviors, while one quarter had engaged in 4 or more of the risky behaviors listed, indicating a need for secondary prevention methods to be used by primary care providers.

### **Emerging Needs:**

- To identify emerging needs, in order to better anticipate the at-risk populations and identify ongoing trends in the HIV+ population, and to reinforce the need for supportive services, use methods such as: Statistical modeling processes, ADA Data base, Local input, Out of Care survey, Provider survey, and other data sources, e.g., literature search, organization reports, among others

Emerging needs assist planners to identify future needs while still meeting the current needs of the population. Data can be used to provide a picture of not only what populations may be at risk but to identify both future core and supportive service needs.

### **Implementation**

The recommended strategies will be implemented to the fullest extent possible through activities identified by the new Data and Assessment committee of the CHPC and as appropriate through the DPH. Limitations that will apply include the “end of contract period” and allowances for changes that may occur as a result of the Ryan White Treatment Modernization Act. The activities will be included in the updated version of the Comprehensive Plan. In October 2007, the SWC and the CPG will merge their planning bodies. During their first year 2008, they will develop a combined Comprehensive Plan. The early implementation strategies will be included in the new plan, as will other strategies that will be developed during their first year.

The following implementation activities were created by the Data Work Group upon completion of the revised SCSN and creation of the new recommendations. These strategies were devised with the intent of having the CT HIV Planning Consortium begin to carry them out during the process of combining of the two planning bodies and to be included in the update of the Comprehensive Plan.

#### *Service Needs and Utilization*

- Contact and work with the CT DPH, the Office of Rural Health and the Office of Oral Public Health to identify providers who will take clients who are living with HIV.<sup>42</sup>
- Specifically address rural transportation problems, connect with services such as the Hockanum Valley Community Council that provides rides for the elderly and disabled, and explore options identified in the Locally-Coordinated Public Transit Human Services Transportation Plan to find healthcare providers

<sup>42</sup> CT ORH has a mission to “work together to promote the health of persons living in rural Connecticut through education, communication and partnerships, by focusing on the enhancement, access and promotion of quality healthcare for rural Connecticut”

who have made adjustments to their facility or practice to make accessing healthcare easier for rural residents.<sup>43</sup>

- Educate providers to understand that Medical Case Management must be about getting people in to care and keeping them in care, and connect those providers who are serving affected children with Part B and D programs to assist in the provision of case management services. (See resource guide for listing of services in those areas.)

### C. ACTION PLAN

During this year of transition, the CHPC will reassess both the integration of care with prevention services and the appropriateness of the funding allocation process. In addition, the CHPC will continue to carry out the activities identified by the Data Work Group resulting from the recommended strategies from the revised and updated SCSN. More importantly, the CHPC will incorporate all required components of prevention and care planning and service delivery into the one unified plan. This process will be reassessed for areas in which collaboration between care and prevention becomes a requirement for contractors.

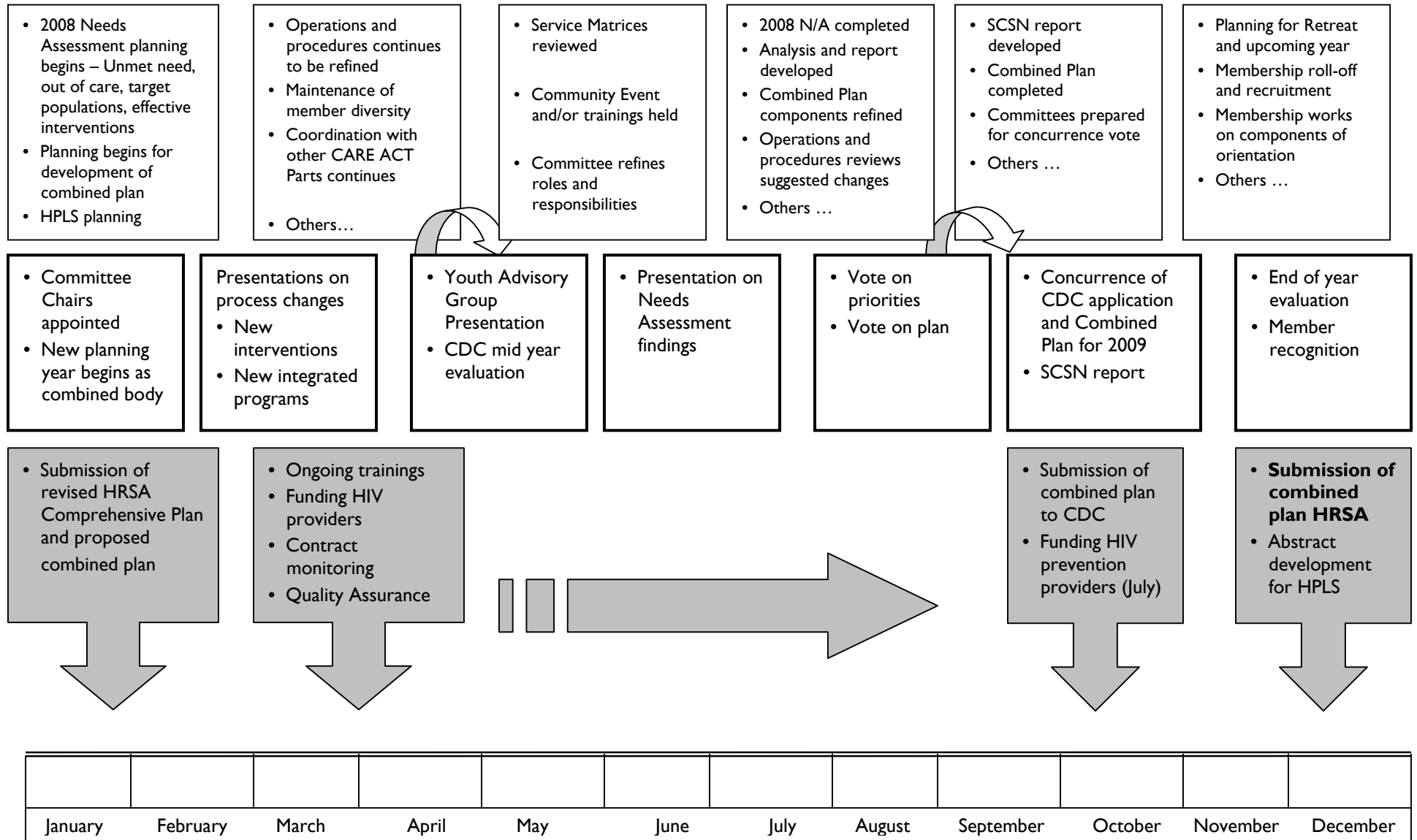
Some objectives and strategies are already being implemented and include training and education for primary care providers and clinicians on secondary prevention methods; focusing on the six core HRSA services as prioritized; gathering further information on the additional core services resulting from the 2006 Ryan White Modernization Act, assessing the impact of the Modernization Act and gathering additional information on rural and non-urban areas; and continuing efforts to fully integrate comprehensive risk counseling services (CRCS) with medical case management through, for example, coordinated services, co-location, cross training, outreach, and referral.

Following is a timeline that will serve as basic guidance for the development of the fully integrated plan and alignment of service provision/funding with the new care and prevention plan.

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<sup>43</sup> Locally-Coordinated Public Transit Human Services Transportation Plan. This community based plan takes a 'job access' style approach to gather information on who is providing what types of transportation and to where, what sources of funding are used, and what are the gaps in transportation - United We Ride: A federal initiative concerning coordination of transportation services. Negotiations are in process to use the Framework for Action to assist in facilitating discussions among the state agencies to develop a State Action Plan Lisa Rivers, Transportation Supervising Planner, Connecticut Department of Transportation

**THE YEAR OF TRANSITION: 2008 HIV PLANNING TIMELINE FOR FEDERAL REQUIREMENTS**



## SECTION IV:

### MONITORING AND EVALUATION

#### A. ASSESSING OUR PROGRESS

The DPH has instituted various new monitoring and evaluation programs and methods that will provide a more comprehensive picture of changes in the epidemic, care and prevention service needs, provider capacity, resources and legislative issues, including regulatory and treatment guidelines. These include the epidemiological profile, out-of-care surveys, needs assessment surveys, Part A Planning Council reports, contractor site visits, quality assurance audits, and contractor quarterly reports. Client satisfaction surveys will also be implemented to assess client perception of access to needed services and quality of care. Grantee and/or lead agency systems will be monitored through the URS system, quarterly reports, and site visits. Evaluation of program effectiveness and quality of care will be accomplished through quality assurance audits, client satisfaction surveys and URS. The new planning body will now serve as a forum for information dissemination and exchange, advise the CT DPH on the provision of effective health care planning and the promotion, development, coordination, and administration of HIV/AIDS health care, prevention and support services, develop an integrated care and prevention comprehensive plan, establish a collaborative process to identify unmet need, and adjust its focus in response to needs of statewide members, evidence-based interventions and data (e.g., HIV trends), and policy issues. The CHPC will conduct self-evaluation according to its new by laws.

This Comprehensive Statewide Plan will be assessed and revised on a periodic basis when new information is available, or when incidents occurring in the external environment cause elements of the plan to shift. All significant changes will be responsibly communicated to the public, providers, consumers, HRSA and CDC.

#### B. REVIEWING OUR PLAN

##### 1. CURRENT AND PROPOSED SERVICES

The DPH continues to conduct various trainings primarily focusing on cross training among prevention counselors and Ryan White funded medical case managers. Marianne McDougall, DPH's in-house trainer, continues to work with community stakeholders regarding emerging training needs via Capacity Building Training Meetings and through Capacity Building Training Needs Assessments. During the last year, two meetings were held with care and prevention providers in order to gather information on how to integrate care and prevention trainings, as well as to identify specific areas where providers could be cross-trained. Providers also shared additional information on topics to include in the Medical Case Management training curricula. The outcome of the meeting resulted in an agreed upon description of Medical Case Management, and its essential training components (e.g. co-morbidity screening intakes, taking effective and appropriate health/mental histories). The group also identified potential trainers who would be willing to collaborate with the State on providing medical case management trainings in the future. In September 2007, the Continuing Education (CE) series will roll-out and will continue through May 2008. The continuing education workshops will include trainings specific to the needs of HIV Care & Prevention providers. The goal of this statewide initiative will be to provide standard trainings a minimum of twice a year, with elective/supplemental continuing education (CE) workshops occurring throughout the year (35 workshops per year). The CE trainings will encompass a variety of HIV related workshops geared towards the Integration of Care & Prevention. The purpose of the CE trainings is to enable HIV Care & Prevention providers to keep updated on HIV related topics, refresh their skills, and to network with other providers across the state. A copy of the Statewide Training Plan is included at the end of this plan.

## **Expanded & Integrated HIV Testing Opportunity for Disproportionately Affected Populations**

The DPH is also planning to expand and integrate HIV testing to populations disproportionately affected by HIV. If funding is provided by Centers for Disease Control (CDC) for this initiative, the department will implement this testing initiative. The two main objectives of the proposed three year project entitled “Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV, Primarily African Americans, in Connecticut” are: 1) to increase HIV testing opportunities for populations disproportionately affected by HIV—primarily African Americans who are unaware of their HIV status, and 2) to standardize voluntary HIV/AIDS screening as part of routine clinical care in health-care settings in Connecticut. During the first year, DPH will conduct a two part project: one that will focus on integrating routine HIV testing into clinical settings and a second that will use a social networks recruitment strategy in four organizations, that are currently being funded to provide counseling, testing, and referral (CTR), in order to enhance their ability to recruit African Americans who may be unaware of their HIV status, into their counseling and testing services.

Using the CDC funds, the department will support organizations to offer and conduct HIV testing routinely within the context of their clinical practice. The resources to be provided by DPH include rapid test kits, Ora-Sure testing devices, free laboratory services for un-reimbursable tests, capacity building training, and educational materials to increase health care provider’s ability to carry out HIV testing as a routine practice.

**Medical Case Management Retreat:** On August 24, 2007 a retreat for Ryan White medical case managers was sponsored by DPH to provide information and gain feedback regarding the implementation of the medical case management model throughout statewide agencies and health care facilities (e.g. clinics and community health centers). Participants represented Parts A-C. Evaluations of the retreat indicated that participants felt the information provided was valuable and that additional training sessions would be important in ensuring the adaptation to the medical case management model and adherence to standards of care.

**Upcoming Trainings:** Fundamentals of Prevention Counseling: October 22-26, 2007, and Fundamentals of Medical Case Management Training: November 14-15, and 19-20, 2007. The latter training will focus on making medical case management client-centered, on empowerment of the client to self manage his/her disease, assessment of risks, overview and review of Medical Case Management forms, and URS data entry

### *Reviewing the Plan*

The *Plan* will be reviewed through formative and summative process methods. DPH will develop goals and objectives to measure both the progress of key activities, implementation strategies and the outcomes expected for each task. The next step will be to identify existing and potential areas where linkages can occur or be expanded by reviewing current activities of DPH and other statewide planning bodies.

A number of data sources and activities currently in place in Connecticut will allow identification of opportunities to: 1) strengthen current linkages between prevention and care in the current system of HIV care; or, 2) to begin working on developing new proposed linkages. The CHPC will develop a plan to assess existing activities linking prevention and care. The prevention and care plan will be goal driven; have clear measurable objectives; identifiable time frames; and, staff who will monitor the progress of reaching the state’s goals. The overall plan will be monitored by the DPH, AIDS & Chronic Diseases Section in consultation with the CHPC in a format to be determined. The following are the current and proposed activities that will be reviewed to accomplish meeting the goals.

### *State Epidemiological Data*

HIV/AIDS cases and case of other infectious diseases (Hepatitis C and STD, for example) are required to be reported to DPH. Aggregate data are available on the DPH website and can be used by DPH, HIV service

organizations, and other community based organizations for program planning and evaluation. Web data are updated twice a year. HIV/AIDS surveillance data are also disseminated in the Epidemiological Profile (published periodically), through presentations, and through specific data requests.

The DPH HIV/AIDS Surveillance Program conducts several specifically-funded surveillance projects including: 1. Core HIV/AIDS surveillance, responsible for routine HIV/AIDS case reporting, analysis, and dissemination; 2. HIV Incidence, responsible for collection of specific information for newly diagnosed cases that will be used to estimate the number of new infections in Connecticut; 3. Enhanced Perinatal HIV Surveillance, responsible for collecting extended information about HIV positive mothers and their infants to assess compliance with prevention recommendations; 4. HIV Behavioral Surveillance, a repeating three-year project to interview persons in high-risk groups (MSM, IDU, high-risk heterosexuals) to assess trends in risk behavior, HIV testing, and access to prevention services. The HIV/AIDS Surveillance Program also collaborates with the AIDS & Chronic Diseases Section and representatives of various community planning bodies to conduct out-of-care surveys and other needs assessments.

### **HIV Reporting and Maturity of HIV Database**

The DPH HIV/AIDS Surveillance Program maintains an HIV/AIDS surveillance registry (HARS) containing the information collected through the reportable disease system. In October 2007, CDC will be installing eHARS at DPH. This upgrade will include several features that will enhance the HIV/AIDS Surveillance data capabilities in Connecticut. AIDS cases have been reportable since 1982 and constitute the majority of cases in the registry. HIV was made reportable with a code option in 2002. With the code option, HIV cases could not be reported to CDC. In 2005, the code option was removed and de-identified HIV cases could be reported to CDC. In 2006, HIV viral load test results were made reportable. Given that viral load testing is conducted periodically for all HIV infected persons in treatment, this reporting option is allowing DPH to register HIV cases diagnosed prior to when HIV was reportable (prevalent HIV cases). Once this backlog of HIV cases has been caught up, the DPH HIV/AIDS surveillance registry will be considered 'mature' by CDC. CDC generally allows four years for states to catch up with prevalent HIV cases. It is anticipated that most HIV cases in care will be registered by the end of 2008.

### **Early Referral and Linkage Initiative (ERLI)**

The DPH continues to provide new case managers, prevention case managers and HIV counselors trainings to ensure knowledge and familiarity with the integration of care and prevention modules and standards of care. Counseling and testing, prevention outreach and health education and risk reduction services are the primary areas where prevention and care efforts overlap and require a collaborative approach. It is through cross training and education that the case managers are able to comfortably utilize the ERLI form and make appropriate referrals.

As part of the Part B quality assurance audit process, the DPH continues to monitor the ERLI program to determine if an assessment was completed for each client, and if necessary, a referral was made to a risk reduction entity. It is and has been the intent of the DPH to review and improve upon the monitoring protocol for completed client referrals and outcomes.

In addition to the quarterly site visits and chart audits the URS database also tracks client level referrals and outcomes. Health Care and Support Service Health Program Associates continue to cross reference URS and quarterly data submitted by the contractors to ensure early linkages and referrals are conducted and completed.

### **Needs Assessment**

The Needs Assessment is a collaborative data collection and analysis effort among Parts A, B and Prevention that assists in the identification of CT HIV/AIDS service delivery needs. The DPH has contracted with an independent consultant to analyze the data to determine gaps in HIV service delivery and prevention

activities. The results of the survey are reviewed by the DPH and the Ad Hoc Comprehensive Planning Committee for possible opportunities to explore linkages between care and prevention. The second statewide Needs Assessment process will begin in early 2008 and will be overseen by the newly formed Data and Assessment committee of the CHPC.

### Statewide Coordinated Statement of Need (SCSN)

Data collection in FY 2003 was a collaborative effort between Parts A and B to determine the needs and service utilization of persons living with HIV. Subsequent updates and revisions were made in December and approved in 2007. The results supported the substantial need to link prevention and care services. DPH and the Data Work Group reviewed the document, prioritized the recommendations and suggested implementation activities.

### URS Data

The URS/AIDA (upgraded to AIRS/AIDA) system has the capacity to collect data that will determine the degree to which clients are linked with prevention and care. Client level demographics, service utilization and referral information will be made available to the state funded Counseling and Testing sites and Ryan White funded agencies to assess where DPH might be able to make improvements in the linking of prevention and care activities. When this is fully implemented, it is expected that much of the required verification of delivery of referral services may be addressed in this way.

## 2. QUALITY AND COST EFFECTIVENESS

The DPH is committed to assuring that the results of linking prevention and care will improve client-level, community-level, and state-level HIV prevention and care outcomes. It is the vision of the DPH Part B Quality Management Program (QMP) that all PLWHA will maintain or improve linkages to an array of comprehensive health care services that will foster self-efficacy and promote optimal health outcomes. Part B funded-contractors are required to adhere to a minimum of administrative policies, procedures and standards of practice and care to assure that PLWHA receive appropriate, accessible and timely medical case management, psychosocial and supportive services and referrals. Both Part A TGAs and Part B both use these minimum standards. Case Management Standards of Care are posted on the DPH website and are reviewed for updating by HCSS staff at quality management meetings. As a result of the 2005 HRSA/Mosaica site visit, DPH increased its vigilance to collect HIV Viral Load (VL) and CD4 tests from funded contractors. In 2006, all HIV viral load test results were made reportable by laboratories that conduct the tests. This step was taken to improve the completeness of reporting of HIV and AIDS cases, allow monitoring of entry of newly diagnosed people into care, monitor consistency and effectiveness of care, and characterize those groups who may delay entry into care. DPH funded Care Contractors are required to collect HIV VL and CD4 counts at a minimum of every six months and enter the results in the URS. To This data will establish a baseline to measure not only contractor compliance with this requirement, but also assist with identifying the number of clients who are engaged in care. To further increase the capacity to collect these important biological markers, the Department of Social Services, that administers the CADAP application process, has also been directed to collect VL and CD4 test results. Another QMP initiative that has been instituted is the review of client referrals and the status of those referrals. For 2007 QMP has set a benchmark that at least 90% of referrals will be completed. The new URS upgrade will also be PEMS compliant (i.e. active referral tracking and confirmation).

Desired outcomes and indicators for the new *prevention and care* paradigm will be developed by a collaborative effort between the CHPC and DPH. The intent is still to include monitoring methods and time frames in the quality assurance plan. Prevention interventions will also include components of a *continuous quality improvement* model to support the success of the plan:

- Contract monitoring methods, e.g., joint site visits to be conducted for providers of prevention and care
- Review /revise quality assurance standards to fit the model

- Assessment and implementation of training/education for providers and consumers, e.g., cross-training and continuing education
- Collection of data elements
- Evaluation and analysis of URS data

As the unified plan is developed, provisions for evaluation of cost effectiveness and efficiencies will be developed and implemented on several levels. The evaluation process will be continually reviewed and refined. Because care and prevention are funded through different sources, efficacy studies will at best, be assessed through 1) qualitative evaluation, that is, reviewed through client satisfaction surveys, 2) quantitative analysis involving contract monitoring (to ensure that new requirements for collaboration are being met), 3) and by enumerating the number of agencies submitting proposals that incorporate streamlined services through collaborative planning. The cost effectiveness of the plan will be evaluated by comparing the current cost of providing the services to the new proposed services.

**Table 10. Current and Future Outcomes and Indicators for the New Prevention and Care Paradigm**

Outcomes	Indicators
<b>Client Level</b>	
Expedient referrals to prevention/care services (e.g. Comprehensive risk and counseling services, medical case management, core medical services, support services)	<ul style="list-style-type: none"> <li>▪ All clients who need referrals for health care, prevention and support services complete referral process</li> <li>▪ Clients are enrolled, retained in primary care, support services, prevention and other entitlements</li> <li>▪ Clients' nutritional status is improved for weight gain and health maintenance, and improved HIV medication adherence</li> <li>▪ Clients receive comprehensive risk counseling services and develop plan to change high risk behaviors</li> <li>▪ Eligible clients receive appropriate levels of psychological/psychiatric treatment and counseling including, provided by Connecticut licensed mental health professionals</li> </ul>
Services are culturally competent	<ul style="list-style-type: none"> <li>▪ Number of staff knowledgeable about target population: health beliefs, culture, level of communication skills, literacy, etc.</li> <li>▪ Number of staff who can communicate with client's in native language</li> <li>▪ Staff receive annual mandatory training in cultural competence and diversity training</li> </ul>
Clients referred for care, remain in care	<ul style="list-style-type: none"> <li>▪ Number of clients who remain in care over x time</li> <li>▪ All clients who need referrals for health care, prevention and support services complete referral process</li> <li>▪ Eligible clients with access to oral health services and treatment rendered by licensed dental professionals at a minimum of two times yearly</li> <li>▪ Assure access for Ryan White eligible clients to formulary pharmaceuticals through CADAP</li> <li>▪ Adequate transportation services available for clients to access primary medical care appointments and other supportive services to maintain in-care status in system of care</li> <li>▪ Assist eligible clients with emergency needs to sustain health outcomes and maintain in-care status</li> </ul>
Increased quality	<ul style="list-style-type: none"> <li>▪ Measuring client satisfaction</li> <li>▪ Clients enrolled, retained in primary care, support services, prevention and other entitlements</li> <li>▪ Improvement to client biological markers (Viral Load, CD4) and improved health outcomes (e.g. weight gain, health maintenance, improved medication adherence)</li> <li>▪ Clients receive food and/or nutritional supplements to maintain/increase weight to prevent wasting, counteract medication side effects and maintain medication adherence.</li> <li>▪ Clients receive housing related services to enable them to obtain or maintain medical care through provision of stable housing environment</li> <li>▪ Eligible clients receive assistance with health insurance continuation to maintain health outcomes and maintenance</li> </ul>

<b>Community Level</b>	
Decrease number of HIV infections by x%	▪ Number of HIV infections reported to DPH
Decrease number of AIDS cases by x%	▪ Number of AIDS cases reported to DPH
Decrease number of sexually transmitted diseases (e.g. Chlamydia, syphilis, gonorrhea) by x%	▪ Number of STD cases reported to DPH
Increase referrals and enrollment in CADAP	▪ Number of eligible clients enrolled in CADAP
Increase number of HIV+ inmates who receive outreach, education and referral to health care , prevention, and entitlements both pre and post release	▪ Number Of HIV+ inmates who do not return to prison and /or relapse and are enrolled in CADAP
Increase accessible prevention /care services (Possible co-location of services)	▪ Number of clients who access services within a geographic area
Increase the number of clients who access prevention/care services	▪ Number of client who are aware of and access services compared to estimated number of persons at risk for HIV and not in care and are not aware of services
<b>State Level</b>	
Increase cost effectiveness	▪ Cost of providing proposed services compared to current cost
	▪ Proposals reflecting collaborative planning
	▪ Review of data to avoid duplication of services
	▪ Assure an up-to-date CADAP formulary that responds to community needs
Increase efficiency	▪ Improved quality assurance and quality management programs to assess compliance with standards of care and contractual agreements
	▪ Staff ratio needed to provide proposed services compared to current staff ratio
	▪ Number of completed prevention/care referrals
	▪ Upgraded URS
	▪ Required case manager trainings regarding prevention and care relevant topics
	▪ HCSS staff training, and educational updating and development

## C. ANTICIPATED REVISIONS

As articulated throughout this document, this is a transition plan that is subject to change with the creation of the fully integrated care and prevention plan. The Plan is fashioned to hold a steady course, yet to be flexible enough to accommodate changes in data and in external circumstances. It is anticipated that revisions will be made to implementation activities and strategies as the planning year unfolds, and will take into consideration federal changes in guidance (CDC is revising their guidance this year and HRSA is continuing to modify guidance in accordance with the revised core standards). The Comprehensive Plan when written next year, will be assessed and revised on a periodic basis when new information is available, or when incidents occur in the external environment cause elements of the plan to shift. All significant changes will be responsibly communicated to the public, CDC and to HRSA.